Maternal and Child Health Services
Title V Block Grant

State Narrative for Washington

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

To obtain a copy of the Assurances and Certifications, contact:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The Office of Maternal and Child Health (OMCH) has a policy of seeking ongoing input on priorities and programs from partners and stakeholders. We do this through advisory groups; workgroups; direct meetings with partners; surveying parents, providers and community organizations; program specific websites and email boxes; focus groups and working with parent organizations.

The Children with Special Health Care Needs (CSHCN) section convenes the CSHCN Communication Network of contractors, other state and local agencies, parent groups, and others. Network meetings are a statewide forum to inform partners and solicit stakeholder input on programs and policies and to collectively solve access issues.

The autism and epilepsy state implementation grants have advisory groups. The Epilepsy Partnership Committee is helping develop a plan to sustain work of the epilepsy project. The Combating Autism Advisory Council oversees a Community Asset Mapping Project to survey parents and others in several communities about local resources for children with developmental delays like autism. The work helps communities ensure these children get appropriate resources and services in a coordinated, efficient, and timely manner. CSHCN partners are exploring internet avenues to get input from youth with autism and epilepsy.

The CSHCN section surveyed CSHCN coordinators from the local health jurisdiction (LHJs)

about data they collect with the Child Health Intake Form during the intake process for CSHCN. The section met with its contractors to gather input and to improve website utilization. Staff regularly monitor user comments in the input sections of the CSHCN Program, Autism, and Epilepsy websites.

The CSHCN section contracts with Parent to Parent (P2P) and Fathers Network (FN), non-profit support and information programs for families with children with special health care needs, to promote culturally competent family/professional partnerships and to increase parent involvement in planning and policy development. P2P and FN actively involve parents and families in decision making, improving systems of care, and leadership training.

The CSHCN section employs a parent of a child with special health care needs as a family involvement coordinator. This individual works with staff on all CSHCN issues and actively facilitates family consultation and participation with OMCH and at the local, regional, and state levels. More detail on this position is in Section III D, Other MCH Capacity. We take steps to reduce barriers like child care and travel expenses to parents' ability to provide input.

Early Childhood Comprehensive Systems periodically does a formal evaluation, surveying stakeholders at the local, regional and statewide levels. The program also gives and receives input through the state's Early Learning Plan website and in direct meetings with early learning stakeholders.

The Maternal, Infant, Child, and Adolescent Health (MICAH) section assists Medicaid in administering the First Steps Maternity Support Services program (MSS). MICAH gathers input from MSS providers through a provider advisory group, discipline specific clinical workgroups, and an email mailbox for providers and clients. MICAH, Medicaid, and MSS providers share this feedback.

To inform OMCH Mental Health activities, MICAH staff participates in a several partnership groups. One group, the Mental Health Transformation Workgroup, regularly gathers input from local governments, community agencies and other stakeholders.

MICAH's perinatal work is informed by a Perinatal Advisory Committee (PAC) which has a variety of perinatal health care providers, professional organizations, and consumer groups. PAC prioritizes statewide perinatal concerns and makes recommendations to its members and DOH. The Perinatal Regional Network (PRN) Coordinators on the PAC work regionally to coordinate statewide projects. MICAH exchanges input with the PRNs by regular meetings, email and telephone.

The Linking Actions for Unmet Needs in Children's Health project (LAUNCH) gathers community input from the Project LAUNCH Young Child Wellness Council, representing key child serving programs, and from service providers. The local LAUNCH program shares this input with MICAH so it can inform program direction.

MICAH uses statewide focus groups for input from youth and adults on teen pregnancy prevention efforts. The goal is to get input on a specific topic, such as developing media literacy curricula or a media campaign.

In 2009, the state budget crisis led the Governor to disband the State Genetics Advisory Committee, which gave broad input on genetics services. OMCH's Genetics Services staff now uses the Western States Genetic Services Collaborative for input on its programs.
The CHILD Profile Advisory Group includes parents, state agencies, professional associations, LHJs, the state immunization coalition, and health plans. It gives DOH input for decision making on CHILD Profile policy and planning activities. OMCH uses input from a satisfaction survey of parents receiving health promotion mailings to improve the mailings.

The Vaccine Advisory Committee, mostly physicians from a wide range of specialties, makes recommendations to DOH on interventions to control preventable diseases.

Staff and managers from across MCH meet quarterly with the LHJ staff, managers and health directors to share information and conduct strategic planning.

OMCH posted the draft 2011 Block Grant application/2009 report and 2010 Needs Assessment to its website for public input in mid-July, 2010. We notified over 400 people from multiple stakeholder groups, including several parents of CSHCN, seeking their input. We incorporated some comments into the final documents. Others will be considered for future applications. We will post the final documents on our website after submission to HRSA in September 2010.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The Office of Maternal and Child Health (OMCH) built the 2010 Five Year Needs Assessment process on the results of the 2005 Needs Assessment. Two important byproducts of the 2005 Needs Assessment are an on-going process improvement effort and a decision in 2005 to merge the Five Year Needs Assessment with the Office's strategic planning efforts. Since 2006, we have used the process improvement to regularly gather and assess MCH population and service data and share results with our stakeholders. Both OMCH and our partners have been able to use the results in strategic and program planning and to identify if program changes are needed.

To begin the 2010 Needs Assessment, we reviewed the priorities identified in the 2005 process with OMCH leadership and with internal and external stakeholders at the early stages of the needs assessment. Their input affirmed that the priorities were still valid and no changes were needed. Internal and external stakeholders participated in the 2010 Five Year Needs Assessment. Section 1c. Methodology of the 2010 Needs Assessment describes on-going stakeholder involvement and two surveys we sent
to a cross section of external stakeholders. The OMCH priorities are

1. Adequate nutrition and physical activity
2. Lifestyles free of substance use and addiction
3. Optimal mental health and healthy relationships
4. Health equity
5. Safe and healthy communities
6. Healthy physical growth and cognitive development
7. Sexually responsible and healthy adolescents and women
8. Access to preventive and treatment services for the maternal and child population
9. Quality screening, identification, intervention and care

The priorities are a strong foundation for the current programs of the Office and its partners. They still accurately reflect the needs of Washington's maternal and child population and relate to services and activities that touch on all MCH populations.

Since the priorities are very broad, we asked stakeholders to define and choose among sub-priorities that drill down into each of OMCH's nine priorities separately. Our goal was to have more focused and concrete sub-priorities that would help frame Office and program objectives. Then, midway through the 2010 NA process, another significant budget cut was proposed. At the same time, there was a proposal from the Governor and legislators for the Department of Health (DOH) to reorganize OMCH services. Since OMCH had already experienced cuts and anticipated more in the future, we realized a mid-course shift in the 2010 NA process was prudent. It became clear that the Office needed to focus its attention on preserving and enhancing core strategies that cross the nine priorities instead of defining sub-priorities that drill down separately into each of the nine priorities.

Below are major findings from the Needs Assessment:

Washington's MCH population strengths and needs:

- Adult women are relatively well-educated, employed, and understand the need for and how to stay healthy.

- The birthrate in women 30 and over has increased. The teen pregnancy rate remains low. The rates of unintended pregnancies, C-sections and pregnant women who are obese or overweight are high.
- There are income related disparities among pregnant women including access to 1st trimester prenatal care and smoking.
- While Washington has a very low overall infant mortality rate, there is a notable disparity for both African Americans and Native Americans.
- Children and youth have elevated rates of obesity and being overweight. These rates are higher among minority youth and children from 2-5 years who receive WIC services.
- While youth generally report feeling safe at school, bullying and increasingly physical fighting are important factors for some students.
- Suicide is the second leading cause of death for youth aged 10 to 24.
- About 14% of children and youth under 17 have a special health care need. There is a higher prevalence of these needs in African American and mixed race children, and among those in low income households.
- Young adults with special health care needs face barriers transitioning to adult care.

Changes in the state MCH program or system capacity since the last 5-year NA:

- Many of the changes in state MCH program and system capacity are due to the overall economic downturn and reduced state revenues in Washington.
- In the last two years, OMCH was cut approximately $2 million of state general fund (29%) and approximately 8.9 FTEs (10%). We are anticipating a couple of more years of economic constraints to work through.
- Decreased employment in the recession has likely reduced access to health insurance and services for the MCH population.
- Two major funding sources from state government, the tobacco settlement and state-funded universal vaccine purchasing, have ended. Foundation funding and charitable donations to MCH services in the community have also decreased.
- Budget changes in other state agencies have impacted MCH populations. For example, First Steps, a DOH-Medicaid collaboration for services to low income pregnant women, recently had a 20% budget cut. Since Medicaid accounts for 48% of Washington's births, First Steps is important to improve the state's birth outcomes.
- The number of primary care providers for MCH patients is decreasing. This is especially so for obstetric providers.
- Washington's MCH population continues to benefit from a "culture of collaboration" among many groups--both public and private, local and statewide--working with them.
- The Governor's personal interest in the MCH population has helped broaden eligibility to health insurance for low income children. She also established the Department of Early Learning, focusing on children from birth to age 6.

We think the MCH priorities will continue to support improved outcomes for the MCH population and strengthen our partnerships. They will also continue to help shape strategic planning processes at OMCH and DOH.

III. State Overview

A. Overview

Washington State encompasses over 66,000 square miles of the northwest corner of the United States. It is bordered north and south by British Columbia and Oregon, east and west by Idaho and the Pacific Ocean. The Cascade Mountains divide the state into distinct climatic areas. A mild, humid climate predominates in the western part of the state. The climate is drier and has a wider temperature range east of the Cascade Range

Population Density

In 2009, the average population density in Washington was 100.3 persons per square mile. The national rate from the 2009 Population Estimates Program is reported at 82.6 persons per square mile (1). In 2009, about 75% of Washington's population was concentrated west of the Cascades. The three most populous counties, King, Pierce, and Snohomish are located on and prosper from Puget Sound. Another western county, Clark, gains economically from proximity to Portland, Oregon. The city of Spokane and Spokane County in Eastern Washington are near enough to benefit from Coeur d'Alene, Idaho.

Geography, climate, and economic resources influence Washington's population distribution. (see attached map). Population density estimates for 2009 range from 906 persons per square mile in King County to less than 4 persons per square mile in Garfield and Ferry counties (1). Washington has 39 counties, each with its own local government. These counties form 35 independent local health jurisdictions (LHJs), funded with varying amounts of federal, state, and local dollars.

Population

Washington's population continues to grow. The 2000 Census indicated the state's population was 5,894,143, an increase of 21.1% since the 1990 Census (1). The Population Estimates Program intercensal population estimate for the state in 2009 was 6,664,195 (1).

According to the 2000 Census, Washington ranked seventh in the country in numerical population growth and tenth in percentage population growth since 1990 (1). The growth continues in Washington State's population. In 2009, the Washington State population grew by 1.5% (1). According to the Census Bureau, Washington's population grew by 12.7% between 2000 and 2009 compared to 8.8% for the nation. As a state, Washington ranked 13th in population growth during this time frame (1).

In 2009 the natural increase was 39,835 per year, an increase that has been observed since 2006, primarily due to a larger number of births. Net migration (people moving into the state versus people moving out) decreased from 42,720 in 2001 to an estimated 25,833 in 2003 (1). In 2009 the net migration into Washington State increased to 58,157 (1).

Race/Ethnicity

The majority of Washington's population identifies itself as White and non-Hispanic. In the 2000 Census, 81.8% of Washington's population reported its race as White, 5.5% Asian, 3.2% Black, 1.6% American Indian or Alaskan Native, 0.4% Native Hawaiian and other Pacific Islander, and 3.9% other. Individuals who reported two or more races accounted for 3.6%. Individuals who reported Hispanic or Latino ethnicity were 7.5% (1). Although the majority of Washington's population remains White and non-Hispanic, the state's other race and ethnic minority populations increased rapidly in the last decade. Together, non-Whites and Hispanics in Washington increased from 13.2% of the overall population in 1990 to 21% (1,241,631) of the

population in 2000. The state population of Asian/Pacific Islanders increased by 78%; Blacks by 35%; and American Indians, Alaska Natives, and Aleuts by 29% (1).

The most recent population estimates produced by Washington State Office of Financial Management (OFM) in 2006 predict a general increasing trend among the population of non-White and Hispanic residents (2). Between 2000 and 2010, the estimated population increase is projected to vary widely by race and ethnicity. The estimated population increase was 12.4% for White, 23.6% for Black, 17.4% for Alaska Native and American Indian, 45.1% for Asian and Pacific Islander, and 38.4% for those of two or more races. In addition, the estimated population increase for those of Hispanic Origin is 47.5% between 2000 and 2010 (3).

Washington is experiencing a significant growth in its Hispanic population. The Hispanic population in Washington State has more than doubled since the 1990 Census, from 214,570 in 1990, to 441,509 in 2000. The estimated Hispanic population in 2010 is 651,027. (3)
Counties with large proportions of Hispanics tend to be located in rural areas of Eastern and Central Washington. In Adams County, the Hispanic population rose from 32.8% in 1990 to 47.1% in 2000, and to 54.1% in 2008; Franklin County saw an increase from 30.2% to 46.7%, and to 59.3% in 2008; and Yakima County saw an increase from 23.9% to 35.9%, and to 42.5% in 2008 (4). The 2000 Census data showed that while Hispanics make up a large proportion of the population in these Eastern and Central Washington counties, most Hispanics live in King, Pierce, and Snohomish counties. The majority (74.7%) of Hispanics in Washington are from Mexico, 20.6% are from other countries (Central and South America), 3.7% from Puerto Rico, and 1.0% from Cuba (1). In 2000, there were approximately 289,000 migrant and seasonal farm workers and dependents living in Washington, most of whom were Hispanic (5). Migrant and seasonal farm workers are more likely to face language barriers, and to have low family incomes and limited transportation options. Most rely on community and migrant health centers for their health care.

Blacks and Asian/Pacific Islanders are predominantly located in urban areas west of the Cascades. Approximately 54% of Asian/Pacific Islanders and 48% of Blacks resided in King County alone in 2008 (6).
There are also 29 federally recognized American Indian tribes throughout Washington with varying populations and land areas. There are seven additional tribes, some of which are seeking federal recognition.

Languages

According to the 2006-2008 American Community Survey 3-year estimates, approximately 18.8%, or 209,276, of Washington's children age 5-17 years speak a language other than English at home (1). Of these children, 55.8% speak Spanish, 21.4% speak Asian and Pacific Islander languages, 17.9% speak other Indo-European languages, and 5.0% speak other languages (1). A similar figure of 17.1%, or 710,729, of the adult population age 18-64 years does not speak English at home (1). Of those who speak another language at home, 71.2% of the children and 50.6% of the adults speak English "very well" (1). Approximately 10% of the children and 26% of the adults, speak English "not well" or "not at all" (1). Approximately 83,484 (8%) students were enrolled in the Transitional Bilingual program in Washington State for the 2008-2009 school year (7).

Age

The 2000 Census population counts show that almost 22%, or 1.29 million of the estimated 5.9 million people in Washington in 2000, were women of reproductive age (age 15-44 years) (1). Nearly 29%, or 1.68 million, were children age 19 years and younger. There were over 125,000 women ages 15 to17 years. A state forecast predicts that over the next 30 years, as the children of baby boomers reach adulthood, the number of women of reproductive age will increase substantially (8).

2009 population estimates show that 20%, or 1.35 million of the estimated 6.67 million people in Washington, were women of reproductive age (age 15-44 years) (9). Nearly 27%, or 1.78 million, were children age 19 years and younger. There were over 135,000 women ages 15 to 17 years (9).

In 2009, there were an estimated 1,142,329 children and adolescents aged 5 to 17 in Washington (9). The school age population (age 5 --17 years) is expected to remain stable through 2010 and then gradually increase.

In 2007, there were 88,921 births in Washington State (10). In 2008, there were 90,270 births in Washington State (10). Birth and pregnancy rates among women 15-24 years declined substantially from 1990-2003, but no clear pattern has emerged recently (10).

Urban/Rural

91% of population growth between 2000 and 2009 occurred in the state's urban counties, where the majority of the population lives. While there are many rural areas in Western Washington, the most rural counties are located in Eastern Washington. Rural county residents tend to be older and to have lower median household incomes, higher poverty rates, and higher unemployment rates. Rural counties are less diverse than urban counties. Hispanics and American Indians account for a larger share of their minority populations. There is a higher percent of uninsured residents and residents enrolled in Medicaid in rural counties (11).

A recent review of hospital utilization rates and mortality rates showed poorer outcomes in rural areas. The overall rates of hospitalization and hospitalization rates for cancers and diabetes are significantly higher in rural areas of the state. Some mortality rates are also significantly higher, including the overall mortality rate and rates for the younger population (ages 1 -- 24) and for deaths from transportation accidents, suicides, and diabetes. Many factors may contribute to these poorer outcomes including geographic isolation and decreased access to care, the lower socio-economic status of residents and their older age (11).

Economy

Washington State faces the same challenges as many other states with large budget deficits, high unemployment, a depressed real estate market, housing foreclosures, and rising fuel prices and continues to suffer from an economic slowdown. According to the Bureau of Labor Statistics, Washington State's seasonally adjusted unemployment rate in May 2010 was 9.1, slightly lower than the 9.3% for April 2010. The US rate was 9.7% in May 2010 which is slightly lower than in previous months. There was no significant job growth in any major industry or sector. (12)

The budget for the 2009-2011 biennium was adopted after resolving a $9.0 billion shortfall for the two year biennium (13). Several years of economic doldrums, combined with spending constraints and spending limits from voter-approved initiatives, have produced a continuing budget crisis for Washington. The legislature just adopted a supplemental budget for FY10 that decreased expenditures to meet another $2.6 billion shortfall. In order to meet anticipated shortfalls, state agencies have been under a number of freeze directives from both the Governor and the Legislature. Freezes have impacted hiring, contracts, equipment purchases and travel. The first freeze was enacted in August 2008 and continues through at least June 2010. The impact on the Department of Health's budget is noted in Section V.A and V.B.

In the past, state revenue surpluses have been available to backfill revenue shortfalls faced by local governments. Continuing budget problems greatly reduce the state's capacity to subsidize local government revenue shortfalls. The result is that many local programs are struggling

financially. At the same time, economic hard times have increased the need for public health services at the local level, so the current decrease in funding is having a major impact on local public health. As the economic slowdown and state fiscal crisis continue, future reductions in local public health are expected. LHJs are currently being forced to reduce staff and programs. In 2009-2011, approximately $10.7 million in MCHBG allocations will be distributed among the 35 local public health agencies in Washington, a 2.7% reduction from what they received in 2007-2009. Finally, in the second biennial year, LHJ's will receive a 10% reduction in State Oral Health funding in response to recent legislation. Termination of an interagency contract with the Department of Early Learning means that beginning in CY2011, LHJ's will no longer receive funding for activities related to child care issues.

As a result of the budget cuts, protracted fiscal constraints, and anticipating that they will continue into the future, local health jurisdiction leaders are meeting with Department of Health senior management to identify what activities are core and what can be dropped. This initiative, Reshaping Public Health, is looking at significantly changing the future direction and emphasis of public health in Washington State.

To date, they have identified four core areas to protect:
1. Preventing and rapidly responding to community health threats
2. Safe food and water
3. Healthier Washingtonians with reduced health care costs
4. Access to safe, quality health care

Poverty and Health Insurance

According to the 2008 Washington State Population Survey, an estimated 26.2% of households had a family income below 200% of the federal poverty level (FPL) and an estimated 9.6% of households had an income below 100% FPL. Approximately 28.8% of households with children under 18 were below 200% FPL (9) . According to the 2006-2008 American Community Survey 3-year estimates, an estimated 12.4% of Washington families with related children under 18 years were below 100% FPL (1). Overall, an estimated 15.1% of children were living below 100% FPL and 6.5% were living below 50% FPL (1).

The 2008 Washington State Population Survey indicated that the percent of Washington residents without health insurance has stayed the same since 2006 (9). Among the general population, 11% were uninsured in 2008, while 10.6% were uninsured in 2006. The percent of uninsured children decreased slightly from 5.0% in 2006 to 4.6% in 2008; however, this is not a statistically significant change.

The Department of Social and Health Services Medicaid Purchasing Administration (MPA) funds health care services to low income people in Washington, primarily through the federal/state Medicaid partnership. In 2008, Medicaid covered pregnant women up to 185% FPL and paid for prenatal care and deliveries for approximately 48% of state births (14). The Take Charge program provided family planning for men and women with incomes at or below 200% FPL. The State Children's Health Insurance Program (SCHIP) provided health coverage for children of families with incomes between 200% and 250% FPL. In 2009 the SCHIP income limit was increased to 300% FPL.

Washington State has been a national leader in giving low-income families access to health insurance. For example, prior to SCHIP, Washington was one of only four states providing Medicaid coverage to children at or above poverty level. When SCHIP was adopted in Washington State in 2000 the Medicaid income limit for children was already up to 200% FPL. SCHIP expanded coverage to low income children up to 250% FPL. In 2006, Washington re-established the Children's Health Program to provide coverage to non-citizen children up to 100% FPL. Then in 2007, the state increased the income limit for the Children's Health program to 250% FPL to mirror the income limit for SCHIP. In 2008 the state consolidated Medicaid,

Children's Health, and SCHIP programs under a single umbrella name "Apple Health for Kids". The benefit package under "Apple Health for Kids" is the full-scope of Medicaid benefits. The Apple Health for Kids Hotline does outreach to connect parents with Medicaid and SCHIP and to provide information about children's health services. Other legislation provides incentives to primary care providers to become medical homes for children and families.

OMCH works closely with MPA to sponsor outreach efforts designed to increase enrollment of children. Washington's statewide network of community, rural and migrant health centers, public hospital-affiliated clinics, and local public health jurisdictions serving low-income and/or special populations also supports access to health services.

(1)US Census Bureau, American Factfinder. (http://Factfinder.census.gov)

(2) Washington State Office of Financial Management (OFM), Population, http://www.ofm.wa.gov/pop/default.asp

(3) Washington State Office of Financial Management (OFM), Projections of the State Population, http://www.ofm.wa.gov/pop/race/projections/default.asp

(4) OMF http://www.ofm.wa.gov/pop/race/minoritygraphics/hispanic08.pdf

(5) Larson A.C. Migrant and seasonal farm worker enumeration profiles study: Washington. Bethesda (MD): U.S. Department of Health and Human Services, Bureau of Primary Health Care; September, 2000)

(6) OFM http://www.ofm.wa.gov/pop/race/minoritygraphics/api08.pdf

(7) Washington State Office of Superintendent of Public Instruction School Report Card, 2009).

(8) Office of Financial Management http://www.ofm.wa.gov/pop

(9) Washington State Office of Financial Management, Research and Data, State Population Survey. http://www.ofm.wa.gov/sps/default.asp.

(10) Washington State Vital Statistics, Center for Health Statistics, 2008.

(11) Washington State Department of Health, What is different about rural Washington: a rural health snapshot, February, 2006. (http://www.doh.wa.gov/hsqa/ocrh/WRHAP/WARuralSnapshot.pdf)

(12)Washington State Employment Security Department, Labor Market and Economic analysis, Washington State Employment Situation Report for March 2010

(13) Washington State Economic and Revenue Forecast Council, http://www.erfc.wa.gov/.asp

(14) First Steps Database. Personal communication from Laurie Cawthon, Washington Department of Social and Health Services, Research and Data Analysis, May, 2010.

An attachment is included in this section.

B. Agency Capacity

The Office of Maternal and Child Health (OMCH) works to protect and improve the health of people in Washington State with a focus on women, infants, children, adolescents, and families. OMCH programs work in close partnership with state and local agencies and consumers to promote effective health policies and quality systems of care. Maternal and child health (MCH)

data are collected, analyzed, and shared with other agencies and organizations to help ensure sound decision-making around health care policies and practices. OMCH program activities emphasize infrastructure-building and population-based activities through preventive health information and educational messages to the public and to health care providers about early identification of health issues, referral and linkage to services, and coordination of services.

OMCH is responsible for administering the Title V Block Grant, Washington State General Funds, Title XIX Medicaid Administrative Match, the Centers for Disease Control and Prevention (CDC) Immunization Grant, and a variety of other federal grants pertinent to MCH priorities and performance measures. OMCH contracts with 35 local health jurisdictions (LHJs) and several community-based organizations, universities and hospitals, direct service providers, family organizations, and others to address MCH priorities and state and national performance measures.

Capacity for better understanding cultural competence as an office and for staff has improved over the years due to continued participation in the division level Multicultural Workgroup and ongoing training. In addition, the Community and Family Health Division established a division wide Health Disparities Workgroup that OMCH staff serves on. This workgroup surveyed all the programs in the division for information about activities that aim to address health disparities. Statewide, the Legislature passed a bill creating the Governor's Interagency Council on Health Disparities. The Department of Health serves on the council. This Council adopted recommendations to eliminate health disparities through education, healthcare workforce diversity, health insurance coverage, obesity and diabetes. They are now charged with developing an action plan to implement these recommendations through 2012.

Each of the five specialized sections within OMCH supports programs to help create infrastructure and provide population based services, and enabling services. The Office generally does not fund direct services, but can support a "last-stop safety net" when there is a major gap in services for the maternal and child health (MCH) population Each section has a specific focus. Two sections focus on distinct Title V populations: one on Maternal, Infant, Child and Adolescent Health, and the other on Children with Special Health Care Needs. The other sections, Genetic Services, Immunization Program/CHILD Profile, and MCH Assessment, and the Oral Health program (which is part of the Administration section) focus on issues that encompass the entire MCH population. The Administration section is the sixth section in the office and supports all of the specialized sections. A brief description of the basic role of each OMCH section follows.

MCH Assessment (MCHA)

This section, with 12.4 full time equivalents (FTEs), provides data, analysis, research, surveillance, and consultative support and management of all assessment activities in OMCH. To ensure that OMCH activities are data driven, MCHA works collaboratively with its sister OMCH sections. MCHA assigns epidemiologists as liaisons and advisors to other OMCH sections. These epidemiologists routinely meet with their assigned section's staff and manager to discuss and interpret data related to a specific program. Together they review data on past performance and set future objectives and targets for the program. This assures that the program's objectives and targets are based on data trends across multiple years. It also helps focus the programs activities where they can have the most impact.

MCHA also has a lead epidemiologist for the MCH Block Grant application process. The MCHA grant lead regularly meets with program staff and managers to discuss and interpret performance and outcome data related to each program. In addition, the MCHA Block Grant epidemiologist lead consults and works in collaboration with staff from non-MCH programs and outside state agencies to solicit additional data needed to complete the grant application and report.

MCHA sees the consultation and collaboration described above as critical to OMCH's

overarching goal of protecting and improving the health of the MCH population of Washington State.

Specific MCHA activities include leading the Five Year Needs Assessment process, reporting performance measures and health indicator data; administering ongoing surveys such as the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Healthy Youth Survey (a biennial survey of 6th, 8th, 10th and 12th graders in public schools), conducting surveillance through a variety of mechanisms such as collecting and analyzing data from child death reviews, cluster investigations, and birth defects surveillance; and implementing State Systems Development Initiative activities. MCHA also designs and implements other surveys as needed and responds to data requests from OMCH, other areas of the Department of Health, local health jurisdictions, other state agencies and other external stakeholders. The OMCH Assessment unit participates in the HRSA Graduate Student Intern Program, mentors graduate practicum students, as well as other workforce development programs like the Council of State and Territorial Epidemiologists fellowships as part of its regular functioning.

Maternal, Infant, Child and Adolescent Health (MICAH)

In 2009, the Maternal and Infant Health section and the Child and Adolescent Health section merged to form the Maternal, Infant, Child and Adolescent Health (MICAH) section. MICAH is comprised of 23.8 FTEs. It is committed to two primary goals: 1) to identify and implement effective strategies to protect and improve the health of women, infants and families and 2) to promote, support, and provide public health leadership for state and community-based systems that assure the health and well-being of children, adolescents, and families in Washington State. Focusing on pregnant and post-partum women and their infants, MICAH works to improve birth outcomes by promoting quality health and support services for women of childbearing age. This includes supporting these women in making choices to adopt and maintain healthy behaviors and ensuring that women and infants, especially those in vulnerable populations, have equal access to quality health and support services that meet their needs. This work is accomplished through monitoring trends in data, maintaining a 1-800 hotline resource and referral number, and by working collaboratively with private and public healthcare partners and contractors to improve access and quality of health services. MICAH also promotes the use of national guidelines for well child and adolescent screening and referral, family support and leadership, teen pregnancy prevention, youth development, promotion of social emotional wellbeing and mental health, and child care health consultation. In partnership with other agencies, MICAH promotes health in early learning and school readiness.

Immunization Program/CHILD Profile (IPCP)

IPCP is comprised of 27 FTEs and committed to two primary goals: 1) preventing the occurrence and transmission of childhood, adolescent, and adult vaccine-preventable diseases; and 2) ensuring that parents, health care providers, and state and local health agencies are working together to promote healthy families and increase use of preventive health care for children from birth to age six years. The section has created partnerships with the Washington Chapter of the American Academy of Pediatrics, the Washington Academy of Family Physicians, a Vaccine Advisory Committee of expert physicians, a statewide immunization coalition, and all local health jurisdictions. IPCP maintains the state's Immunization Registry and coordinates the Child Profile Health Promotion System which regularly mails health promotion materials to households with children under six years of age. Seventeen mailings are sent to the households with young children, over the period from birth through age six.

Children with Special Health Care Needs (CSHCN)

The CSHCN section has a total of 10.9 FTEs. The program promotes integrated systems of care that ensure that children with special health care needs and their families have the opportunity to achieve the healthiest life possible and develop to their fullest potential. CSHCN staff provide

leadership in addressing health system issues that affect this population; work with families and other leaders to influence priority setting, planning and policy development; and support community efforts in assessing the health and well-being of children with special health care needs and their families. This work is carried out through partnerships with other state-level agencies and contractual relationships with LHJs, private and non-profit agencies, the University of Washington, Seattle Children's, other tertiary care centers, and family organizations. These contracts and partnerships significantly extend CSHCN program capacity in the areas of policy development, assessment, provider education, and family leadership development. A small amount of funding is used for medically necessary services and equipment for children whose families are at or below the Federal Poverty Level for Medicaid not covered by any other source of payment.

Genetic Services Section (GSS)

Genetic Services, with 8.1 FTEs, is focused on assuring high quality comprehensive genetic services and early hearing-loss detection, diagnosis, and intervention (EHDDI) throughout the state. The section serves as a resource for accurate, up-to-date information, promotes educational opportunities for health and social service providers, and evaluates quality, trends, and access to services.

OMCH Administration

This section has a total of 6.5 FTEs and provides office management and administrative support to OMCH as a whole through policy and fiscal development and oversight. The Oral Health Program is located in the Administration section because it serves the entire MCH population and works with all of the sections within the office. Oral Health works through partnerships with other state-level agencies and contractual relationships with LHJs. This program has partnered with various programs internally within DOH and with external stakeholders like Washington State Oral Health Coalition, Washington State Dental Association, Washington State Dental Hygiene Association, Community Health Centers, and University of Washington School of Dentistry to improve oral health in the state.

C. Organizational Structure

The Department of Health (DOH) is Washington's statewide public health agency. It is located in the Executive Branch of state government, with the Secretary of Health reporting directly to the Governor. DOH includes five major divisions: Office of the Secretary;
Division of Community and Family Health (CFH); Division of Environmental Health; Epidemiology, Health Statistics and Public Health Laboratories Division; and Health Systems Quality Assurance. The Office of Maternal and Child Health (OMCH) is one of four offices in the Division of Community and Family Health. In Washington State, the Children with Special Health Care Needs Program is part of OMCH.

The Department of Health was created as a single state agency in 1989. The legislative intent was to focus "the need for a strong, clear focus on health issues in state government and among state health agencies to give expression to the needs of individual citizens and local communities as they seek to preserve the public health. It is the intent of the legislature to form such focus by creating a single department in state government with the primary responsibilities for the preservation of public health, monitoring health care costs, the maintenance of minimal standards for quality in health care delivery, and the general oversight and planning for all the state's activities as they relate to the health of its citizenry.

Further, it is the intent of the legislature to improve illness and injury prevention and health promotion, and restore the confidence of the citizenry in the efficient and accountable expenditure of public funds on health activities that further the mission of the agency via grants and contracts,

and to ensure that this new health agency delivers quality health services in an efficient, effective, and economical manner that is faithful and responsive to policies established by the legislature."

As such, DOH, through the Office of the Assistant Secretary for Community and Family Health and OMCH, is responsible for the overall administration of programs focusing on the health of the MCH population.

On a program by program basis, OMCH staff collaborates extensively with staff in the other CFH offices and in the other DOH divisions. Some areas our internal collaborators address are health statistics; the state Public Health Laboratory, epidemiology; chronic, infectious and communicable disease; reproductive health; tobacco control and prevention; Women, Infants and Children (WIC); health promotion; environmental health; community health systems; and regulation and licensing of health facilities and professionals. They are described in detail in Section IIIE, the State Agency Collaboration section of this application.

Organization charts for the Department of Health, the Division of Community and Family Health and the Office of Maternal and Child Health are attached. These organizational charts are also at the following internet links: 1) Department of Health organization chart at http://www.doh.wa.gov/Org/org.htm 2) Division of Community and Family Health chart at http://www.doh.wa.gov/cfh/CFHOrgChart/CFHorg.htm. 3) Office of Maternal and Child Health chart at http://www.doh.wa.gov/cfh/mch/documents/MCHOrg.pdf.

An attachment is included in this section.

D. Other MCH Capacity

The Office of Maternal and Child Health (OMCH) has staff in a variety of specialty areas including: epidemiology, public health administration, public health nursing, social work, oral health, children with special health care needs, obstetrics, perinatal care, adolescents, early childhood, health education, nutrition, genetics, immunizations, and psychology.

The family perspective is an integral component of developing high quality, culturally competent programs and public policy. OMCH employs a parent of a child with special health care needs as a full-time family involvement coordinator for the CSHCN program. This individual works with staff on all CSHCN issues and plays an instrumental role in facilitating family consultation and participation within OMCH and at the local, regional, and state level. OMCH's Family Involvement Coordinator takes a leadership role in activities to increase family involvement in children with special health care needs policy and program development, including implementation of the family leadership strategic plan to increase integrated systems of care for CSHCN and their families. The Family Involvement Coordinator also develops and manages contracts, grants, and other program activities related to children with special health care needs and the broader maternal and child health population. The current Family Involvement Coordinator for OMCH is one of five delegates from Washington to the Association of Maternal and Child Health Programs (AMCHP).

The majority of staff are located in Olympia, Washington. The Genetic Services section is located in Kent, Washington, which is south of Seattle and Shoreline, Washington which is on the northern edge of Seattle.

Following are brief biographical sketches of Department of Health (DOH) senior management and OMCH managers:

Mary Selecky has been the Secretary of Health since 1999. She is a political science and history graduate of the University of Pennsylvania and past president of the Association of State and Territorial Health Officers (ASTHO). Prior to her appointment as Secretary of Health, Mary worked for 20 years as the Administrator of the North East Tri-County Health District in Eastern

Washington.

Dr. Maxine Hayes serves as the Health Officer for DOH. Prior to this, she was the Assistant Secretary of Community and Family Health, the Title V Director, and president of the Association of Maternal and Child Health Programs. Dr. Hayes is Associate Professor of Pediatrics at the University of Washington, School of Medicine and is on the MCH faculty at the University's School of Public Health and Community Medicine. In October 2006, Dr. Maxine Hayes was elected to the Institute of Medicine of the National Academies. The Institute is the principal advisor to the federal government, health care organizations and research institutions on health policy.

Allene Mares became Assistant Secretary for the Division of Community and Family Health in July, 2010. She also directs DOH's Office of Public Health Systems and Development. Allene has over 30 years experience in public health. Prior to coming to DOH, she was the Health Officer/Executive Director for the Cascade City-County Health Department in Great Falls, Montana and the Health Commissioner for Public Health-Dayton & Montgomery County, Ohio. She has also worked in management positions at health departments in Seattle & King County, Seattle, WA, Monterey County, CA and Tacoma-Pierce County Health Department in Tacoma, WA. Allene has a Master's degree in Public Health from the University of Washington and a Bachelor of Science in Nursing from Montana State University.

Mary Wendt was the Assistant Secretary for the Division of Community and Family Health until June, 2010. Mary joined DOH in 2008 after nearly eight years with the Washington State Department of Social and Health Services (DSHS), most recently serving as the Chief Financial Officer for the Mental Health Division. Her prior roles with DSHS include serving as the Office Chief for the Office of Rates Development, where she oversaw professional-level analysts in charge of setting reimbursement rates and policies for the state's Medicaid program. She has also served as the Rural Health Clinic and Federally Qualified Health Center Program Manager for DSHS. Mary has a Master's in Public Administration: Health Administration from Portland State University and a Bachelor's Degree in Biology and Chemistry from the University of Utah.

Jennifer McNamara is the Chief Administrator for Community and Family Health at the Washington State Department of Health. Jennifer is a certified Project Management Professional, past manager of the Department of Health Project Resource Center, and is a twenty five year veteran of state government, serving both Department of Information Services and Department of Transportation previously.

Riley Peters, Ph.D. became the Director of the Office of Maternal and Child Health (OMCH) in June 2007. Dr. Peters has a PhD in epidemiology from the University of Washington. He also holds a Master's in Public Administration with an emphasis in health administration from the University of Southern California. He has worked in local and state public health for over 25 years and served as the manager of the MCH Assessment section for five years.

Amira El-Bastawissi, MBCHB, Ph.D. became Senior Epidemiologist/Manager of the Maternal and Child Health Assessment section, in October, 2009. She has a medical degree from Alexandria University, Egypt and a PhD degree in perinatal epidemiology from University of Texas School of Public Health. Dr. El-Bastawissi worked at the Seattle-King County Department of Public Health before joining the Department of Health in 2002. Prior to her current position, she worked on the evaluation of the Diabetes Collaborative, part of a statewide medical home effort. Dr. El-Bastawissi has over 15 years experience conducting epidemiologic studies, program evaluation, surveillance and health services research with specific expertise in maternal and child health, diabetes, and cancer.

Kathy Chapman, manager of the Maternal, Infant, Child and Adolescent Health section, has a Master's degree in maternal and child health nursing from the University of Washington. She was previously the manager of the Children with Special Health Care Needs Section and also

supervised the MCH Assessment Section for several years. Kathy has worked for more than 20 years in state and local public health programs focusing on maternal and child health issues.

Debra Lochner Doyle, manager of the Genetic Services section, has a Bachelor of Science degree in genetics from the University of Washington and a Master of Science degree in human genetics and genetic counseling from Sarah Lawrence College in New York. She is board certified by the American Board of Medical Genetics and the American Board of Genetic Counseling. She is also the past president of the National Society of Genetic Counselors, a founding member of the Coalition of State Genetic Coordinator, current Board member of the American Board of Genetic Counseling and an Affiliate Instructor with the University of Washington, School of Public Health, Institute for Public Health Genetics.

Maria Nardella is the manager of the Children with Special Health Care Needs section. Maria has more than 20 years experience in state CSHCN programs. She is a Registered Dietitian with a Bachelor of Science degree in nutrition from Cornell University and a Master of Arts in nutrition and mental retardation from the University of Washington, including clinical training at the university-affiliated program.

Janna Bardi, manager of the Immunization Program CHILD Profile section, has a Master's in Public Health in behavioral science and health education from the University of California, Los Angeles. She was previously the manager of the CHILD Profile section before it merged with the Immunization Program in 2005. She has experience in program analysis, policy development, systems development, inter-and intra-agency collaboration, and program evaluation. Janna is a 2003 scholar of the Northwest Public Health Leadership Institute.

Shumei Yun, MD, PhD was Senior Epidemiologist/Manager of the MCH Assessment section until September, 2009. Dr. Yun holds a MD and a Master's in Public Health from Beijing Medical University, and a PhD in nutritional epidemiology from the Cornell University. She joined the Washington State Department of Health in July 2008. Prior to moving to Washington, she worked as a state chronic disease epidemiologist in Missouri for five years.

E. State Agency Coordination

Working with other DOH federal grant programs:

OMCH collaborates with several DOH federal grant programs within the Community and Family Health Division: WIC, HIV/AIDS and Family Planning and Reproductive Health (FPRH).

OMCH, WIC, FPRH and over ten other DOH programs form the Women's Health Resource Network (WHRN)--a forum for DOH-wide input and response to women's health issues and service gaps. Its goal is to help build state and local capacity to address women's health needs. The focus includes data analysis, quality assurance, program services, and health systems changes.

To improve women's health and access to obstetric care, MICAH works with the Offices of Rural Health, Tobacco Control and Prevention, HIV Prevention and Education, and Injury Prevention Program (IPP) and WIC.

MICAH convenes the cross-division Preconception Workgroup of partners from WIC, Chronic Disease Prevention, FPRH, STD program, and others.

OMCH works with DOH's HIV/AIDS program to develop effective policies and programs for HIV/AIDS prevention and care in the MCH population and to increase HIV testing of pregnant women.

WIC and MICAH promote breastfeeding, exchange data, enhance referrals, and address access issues between WIC and Title XIX programs for pregnant women. They also collaborate on policies and practices to promote workplace breastfeeding.

CSHCN, WIC and Newborn Screening cross-train staff and coordinate coverage for special formulas for children on Medicaid. WIC and IPCP collaborate on nutrition materials for CHILD Profile mailings. IPCP works with WIC to enhance immunization rates. MCHA and WIC collaborate to evaluate issues like WIC's impact on adverse pregnancy outcomes.

MICAH trains WIC staff to identify and intervene in cases of domestic violence and child abuse. The Family Violence Prevention Workgroup, with members from OMCH, IPP, Emergency Medical Services, and FPRH plans and evaluates activities and seeks resources to decrease family violence.

The Oral Health program works with chronic disease programs in Community Wellness and Prevention as well as the Office of Rural Health

Working with other state agencies

OMCH collaborates with many state agencies including the Department of Health and Social Services (DSHS), Office of the Superintendent of Public Instruction (OSPI), Department of Early Learning (DEL), Council for Children and Families (CCF), University of Washington, Family Policy Council, Developmental Disabilities Council, Office of the Education Ombudsman, Office of the Insurance Commissioner, Health Care Authority, and Department of Commerce.

1. Washington State Board of Health (SBOH) is an independent 10-member board appointed by the Governor. The Secretary of Health is a required member. OMCH works with SBOH on children's health issues and rulemaking activities. Topics addressed include newborn screening; prenatal screening, HIV testing of pregnant women, immunization requirements for school and child care attendance, genetics, and hearing, vision, and scoliosis screening in schools. The SBOH has a representative on the Medical Home Partnership Committee hosted by CSHCN.

2.We frequently collaborate through interagency groups and public/private partnerships to ensure all stakeholders are at the table. A good example is Early Childhood Comprehensive Systems (ECCS) Grant which MICAH administers. The broad based, public-private ECCS partnership includes the DEL, its Head Start office, Thrive by Five Washington, OSPI, Foundation for Early Learning, Reach Out and Read, CCF, and many other stakeholders. ECCS has five critical components: health, social-emotional development and children's mental health, early care and education, parenting, and family support. Staff work with all OMCH sections to improve systems across these components and link with the state's SAMHSA Project, Linking Actions for Unmet Needs in Children's Health (LAUNCH) grant, as required by both grants. The ECCS partnership is creating an Early Learning Plan for Washington--a strategic plan to assure children are healthy and ready for school. ECCS also works to integrate medical home into health and early literacy activities; integrate Strengthening Families protective factors across early learning systems; develop a Birth to Three plan for the state, and assure mental health is included in services for child well-being. ECCS has convened a stakeholder workgroup to collaborate, examine, and expand our role in home visiting.

3. The Mental Health Transformation Grant (MHT) ends in late 2010 after five years. An MHT Prevention Advisory Group, with members from DSHS, OMCH, OSPI, and SBOH, has been working to promote a public health approach to mental health. This group is now transition planning for the long term continuation of the cross agency, public-private, state-local partnerships established during the MHT. OMCH keeps public health and early learning stakeholders informed about how to coordinate with and influence this work. OMCH staff also promotes a public health approach to mental health on an advisory group to DSHS-Division of Behavioral Health and Recovery (DSHS-DBHR) on children's treatment and services.

4.Healthy Child Care Washington (HCCW) is a MICAH program that works with the DEL, OSPI, the local health jurisdictions (LHJs), other OMCH sections and Division of Environmental Health (EH), to distribute information to Child Care Health Consultants at the LHJ's and child care providers on a variety of topics.

5. Many programs across OMCH collaborate with the Department of Social and Health Services (DSHS) Medicaid Purchasing Administration (MPA) to implement the state Medicaid plan. The CSHCN manager serves on the Title XIX Interagency Advisory Committee.

To improve women's health and access to obstetric care, MICAH collaborates with MPA, the Children's Administration (CA), other agencies; and contractors. First Steps Maternity Support Services (MSS) works to improve early access to prenatal care through its diverse base of providers.

MPA supports PRAMS since data is stratified by Medicaid recipient status and used by the First Steps program to evaluate services effectiveness. MCHA and DSHS collaborate to compare birth outcomes of Medicaid women to others.

MICAH assists DSHS in managing the MSS and childbirth education programs targeting pregnant women under 185% of the Federal Poverty Level. OMCH participates on an oversight committee for a treatment program for chemically dependent pregnant or parenting women and their children with DSHS-DBHR and the CA.

OMCH works with DSHS to provide outreach for the Apple Health for Kids program, which consolidates outreach for Medicaid, SCHIP, and state children's coverage. CSHCN assists MPA with implementing recently expanded publicly funded health coverage for children.
OMCH provides DSHS-DBHR with data to meet Medicaid 1915B waiver requirement to identify the number of children with special health care needs served by both Title V and Mental Health.

CSHCN partners with MPA and LHJs to work with Medicaid managed care plans to meet requirements of the CMS 1915B waiver which requires MPA to identify, track, and coordinate care for children in managed care who are also served by Title V. It also allows families to request an exemption from managed care if needed.

Through CSHCN Communication Network meetings, CSHCN, MPA and health plan representatives work to improve access to and quality of health services for children with special health care needs and to implement quality assurance measures and data sharing for Title V children in Medicaid managed care.

OMCH partners with DSHS-MPA and the Health Care Authority- the two largest purchasers of health care in Washington--to develop performance measures for providers and health plans caring for children . While the focus of this effort is children in publically funded health coverage, all children receiving care in Washington benefit when services meet performance measure targets. DSHS-MPA and IPCP work to maintain and expand partnerships with the state's health plans through a quarterly meeting with health plan quality staff.

CSHCN is also working with managed care plans to identify ways to provide medical homes for all children. Expansion of publicly funded health coverage includes provision of care within a medical home. New legislation in 2008 funded primary care pilots to implement medical home for all patients using a learning collaborative model currently used by CSHCN medical home teams.

CSHCN, Disability Determination Services (DDS) and the Social Security Administration have an

agreement to provide information to families of children under 16 years who apply for Social Security Income (SSI). DDS provides data files of all SSI applicants up to age 16 years to the CSHCN program.

MPA and IPCP have data sharing agreements. They also develop and distribute health promotion materials for parents. MPA is on the CHILD Profile Advisory Group. IPCP works with MPA on the Vaccines for Children (VFC) Program to ensure VFC-qualified children get adequate immunizations. IPCP has an agreement with DSHS to distribute information about development and early intervention services to parents of infants ages 3 to 18 months.

OMCH works with the Division of Developmental Disabilities' Infant Toddler Early Intervention Program (ITEP) to implement Part C of the Individuals with Disabilities Education Act. An interagency agreement of DOH, DSHS, Department of Commerce, Department of Services for the Blind, and OSPI ensures a broad statewide system of early intervention services for eligible children birth to 3 years with disabilities and their families.

OMCH provides state funding match for Medicaid prenatal genetic counseling services. OMCH oversees the program and works with MPA to ensure that up-to-date billing instructions are in place and that MPA has a current directory of qualified providers. Medicaid also covers genetic counseling services for parents of infants up to 90 days after birth. GSS has a data sharing agreement in place with DSHS-ITEP matching their early intervention data with our EHDDI data to evaluate the goal of infants with hearing loss entering early intervention services by six months of age. GSS works with the DSHS- Office of the Deaf and Hard of Hearing to link members of the deaf and hard of hearing community to families with infants diagnosed with hearing loss.

6.Office of the Superintendent of Public Instruction (OSPI): IPCP works with OSPI to distribute child development and school readiness information and with OSPI Health Services on immunization requirements for school entry. OSPI is on the IPCP CHILD Profile Advisory Group. CSHCN participates in monthly OSPI School Nurse Corps (SNC) meetings. SNC supervisors attend MCH Regional meetings. SNC and OMCH participate in each other's regular meetings. Washington State received a Coordinated School Health (CSH) Grant from CDC. This is a partnership between DOH and OSPI. CSHCN and MICAH are on the CSH Interagency Committee and work to align this effort with related adolescent health and mental health planning initiatives. The CSHCN section works with OSPI to identify appropriate health outcomes for CSHCN. OSPI is on the Combating Autism Advisory Council. MICAH works with OSPI and local health jurisdictions to review sexual health education curricula for adherence to the state's Healthy Youth Act and to develop scientific accuracy trainings for school personnel.

7.Department of Early Learning (DEL): DEL partners with MICAH on the ECCS and the MH Transformation grants. It is also on the CHILD Profile Advisory Group and provides materials for CHILD Profile Health Promotion mailings on choosing quality child care.

8.University of Washington (UW): UW's Center on Human Development and Disability (CHDD) receives Leadership Education for Neurodevelopmental Disabilities grants. OMCH uses MCH block grant funds to extend and enhance MCH priorities in the areas of CHILD Profile, nutrition, high-risk infants and children, adolescent transition, medical home, and emotional behavior in very young children. MICAH also works with the CHDD to develop and implement curricula on topics such as improving nutrition, and teen pregnancy prevention. GSS staff works with the UW Center for Health Policy, Center for Genomics Healthcare Equality and the Institute for Public Health Genomics on a variety of training and health systems research endeavors.

9.Washington State Developmental Disabilities Council and Office of the Education Ombudsman are partners on the CSHCN Autism Project.

10.The Council for Children and Families (CCF) partners with IPCP to provide shaken baby and

post partum depression brochures in the CHILD Profile Health Promotion mailings. The OMCH Director is on the boards of CCF and the Family Policy Council.

11.The Oral Health Program has a core advisory group that consists of representatives of the main organizations involved in dental health from the public and private sectors .

12.The Planning Committee for the Healthy Youth Survey , a Washington survey of adolescents, has staff from OMCH and other DOH programs, OSPI, Department of Commerce, DSHS, the Liquor Control Board, and the Governor's Family Policy Council. With other state and local agencies, they form the Washington State Partnership for Youth, whose purpose is to develop a plan for improving adolescent health in Washington State.

Working with Local Health Jurisdictions (LHJs), Schools, and Counties

1.OMCH contracts with 35 LHJs to address maternal and child health needs in local communities. OMCH works with LHJs to oversee contract activities and provide consultation and technical assistance. OMCH administrators and staff meet regularly with the Nursing Directors of LHJs and other local MCH staff through quarterly MCH Regional meetings. DOH works with Nursing Directors to develop key activities, outcomes, and indicators for local public health. MICAH provides technical assistance and data support for the local Child Death Review teams. Oral Health has a list serve for communication with and among LHJs. Until the end of FY2011, Oral Health will train and give technical assistance to the LHJ oral health coordinators. Some LHJ activities are described in the performance measure narratives. A report of LHJ activities is available by contacting OMCH at 360-236-3502 or mch.support@doh.wa.gov.

2.MICAH, the DOH Office of Health Promotion, OSPI, LHJs and other stakeholders collaborate to promote school-based health centers (SBHC). Through a School-Based Health Center Interagency Group they implement the Coordinated School Health Grant; provide technical assistance to existing SBHC and communities interested in starting SBHC. OMCH supports two SBHC's with ongoing funding, has funded others for short term projects, and is exploring ways to increase mental health access and address SBHC provider reimbursement issues.

3.MICAH is the state coordinator for the SAMHSA Project LAUNCH grant to promote young child (0 to 8) wellness at a local and a state systems level. Our local LAUNCH partner, Yakima County, is implementing evidence-based-practices to strengthen family and caregiver skills to promote positive social emotional development. Washington State University is evaluating LAUNCH. ECCS and LAUNCH staff collaborate, benefitting both efforts. The Project LAUNCH Young Child Wellness Council has partners from public and private agencies. LAUNCH, with the Autism Grant, is co-convening a statewide stakeholder to develop a universal developmental screening vision and plan.

Working with Hospitals and Other Specialized Services

1.GSS contracts with Seattle Children's to provide training and technical assistance to birthing hospitals on newborn hearing screening. Seattle Children's Center for Children with Special Needs provides information to families, providers, and policy makers on health issues for children with special health care needs and their families. IPCP works with Seattle Children's to develop and distribute materials for parents of children aged birth to six years on injury prevention and on preventing and treating childhood illnesses. Since Seattle Children's is a regional pediatric referral center, children and families from Alaska and Idaho also benefit from some of these collaborative efforts.

2.Mary Bridge Children's Hospital and Health Center (MB) is the site of an OMCH supported neurodevelopmental center and the Maxillofacial Review Team for Southwest Washington.

3. OMCH contracts with Yakima Valley Memorial Hospital to provide services to MCH population.

4. CSHCN contracts with Sacred Heart Children's Hospital for nutrition services in the Spokane area.

3.Madigan Army Medical Center partners on the CSHCN Autism Project.

4.Neurodevelopmental Centers (NDC): CSHCN provides funding to support the infrastructure of 15 NDCs across the state. NDCs provide evaluation, diagnosis, coordinated treatment planning, and specialized therapy to children with a variety of developmental or neurodevelopmental conditions. These non-profit centers depend on funding from the state and other sources to provide a structure for specialty services.

5.GSS helps fund six of Washington's 30 genetics clinics to provide clinical genetic services for the MCH population and educational outreach to communities. GSS uses annual utilization data from the clinics for program planning and policy development.

6.Four Perinatal Regional Networks coordinate state and regional quality improvement projects to decrease poor pregnancy outcomes. MICAH coordinates and funds this work through contracts with four regional perinatal programs.

7.Perinatal Advisory Committee, staffed by MICAH, brings together representatives of the Perinatal Regional Network, tertiary care centers, professional associations, consumer groups, and state agencies to review and assess perinatal health issues and advise DOH and MPA about policies and practices to improve perinatal and neonatal outcomes.

8.Community Health Clinics (CHC) play a major role in providing access to direct health services as LHJs continue to move toward core public health functions. Most CHCs are First Steps providers and participate in First Steps education updates sponsored by OMCH and MPA.

Working With Tribes
Areas of concern in American Indian Health Commission's (AIHC) 2010-2012 Health Care Delivery Plan are infant mortality, teen pregnancy, immunization rates, and oral health. MICAH, Oral Health, IPCP, the First Steps program, WIC, and tribal liaisons work on strategies to improve health outcomes in Native American mothers and children through AIHC workgroups. MCHA works closely with the Northwest Portland Area Indian Health Board and the Seattle Urban Indian Health Institute on maternal and infant assessment issues.

OMCH and DOH's tribal liaison have expanded and improved communication with tribes. With AIHC, we expanded use of the DOH Tribal Connections website.

Working with Communities, Foundations, and Organizations

1.WithinReach, the state's Healthy Mothers, Healthy Babies organization, works with IPCP to provide information on child health and immunizations and immunization outreach activities through the Immunization Action Coalition of Washington. WithinReach also provides content on accessing health insurance for CHILD Profile Health Promotion mailings.

2.The Autism Society of Washington, Autism Speaks Washington, Family Voices of Washington, Washington PAVE, the Family to Family Health Information Center, and Easter Seals partner with CSHCN on its Autism Project.

3.Epilepsy Foundation Northwest and CSHCN are collaborating on a 3 year grant to DOH to improve community-based system of services for children and youth with epilepsy. Activities focus on medically underserved and rural areas of central Washington, particularly areas with

large Hispanic populations.

4.GSS and Washington Sensory Disabilities Services train providers statewide to work with deaf or hard of hearing children and to conduct a birth-to-three educational program at the annual Deaf Family Weekend.

5.GSS contracts with Washington State Hands and Voices to support the "Guide By Your SideTM Program", a resource for parents of children with or at risk for hearing loss. Trained parent guides provide information and support for families about newborn hearing screening, diagnostic evaluation, early intervention, and other services

6.Foundation for Early Learning (FEL) and IPCP revise and distribute the "Birth to 18 months" and "18 months to 3 years" development charts for parents. The charts address social, emotional, physical, language, motor, and cognitive development and give parents specific activities to support their child's development. FEL and CHILD Profile distribute a booklet on school readiness to parents of 4-year-olds.

7.Washington Dental Service Foundation and Washington State Dairy Council work with IPCP on materials in their areas of expertise for the CHILD Profile mailings.

8.IPCP, CSHCN and MICAH work with health care provider associations including the Washington Chapter of the American Academy of Pediatrics, Washington Association of Family Physicians, Washington State Obstetrics Association and the Washington Medical Association, to provide information on best practices for immunization, quality assurance activities around vaccine use, special projects to increase immunization rates, developmental screening and prenatal practices.

9.Oral Health works with the state dental and dental hygienists associations to reach private dental and dental hygiene providers and also with DOH's Office of Rural Health and the WA Association of Community and Migrant Centers to reach dental providers working in community health centers and other public clinics.

10.OMCH sponsors HRSA Graduate Summer Interns, Council of State and Territorial Epidemiologists fellows and practicum students from the University of Washington.

11.MCHA staff actively participates on many work and advisory groups that impact policy both internal to DOH and statewide. Examples are the Preconception Workgroup, C-section Workgroup, Perinatal Advisory Committee, Child Death Review, Childhood Drowning Policy Task Force, and Coordinated School Health Workgroup.

F. Health Systems Capacity Indicators

Introduction

The Health Systems Capacity Indicators (HSCI) are a group of national indicators designed to measure the capacity of each state to serve certain populations. They address both access and availability to services and programs, often by Medicaid and SCHIP eligibility, and are measured annually. Each HSCI includes a discussion of the factors influencing whether the HSCI has been maintained or has improved, the efforts being made by the program to develop new strategies, interpretations of the data trends, and any association between the measure and the State Systems Development Initiative (SSDI) grant.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	29.2	25.3	21.6	22.2	
Numerator	1187	1042	909	962	
Denominator	405992	412285	420384	433346	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
CHARS data on hospitalizations for 2009 are not yet available.

Notes - 2008
Data for this Health Systems Capacity Indicator (HSCI01) are gathered from the Comprehensive Hospital Abstract Reporting System (CHARS), Washington State's hospital discharge database. The numerator represents the number of hospital discharges for children less than 5 years of age who had a primary diagnosis of asthma (ICD-9 codes 493.0-493.9). The data was accessed using the Community Health Assessment Tool (CHAT) software.

Notes - 2007
Data for this Health Systems Capacity Indicator (HSCI01) are gathered from the Comprehensive Hospital Abstract Reporting System (CHARS), Washington State's hospital discharge database. The numerator represents the number of hospital discharges for children less than 5 years of age who had a primary diagnosis of asthma (ICD-9 codes 493.0-493.9). The data was accessed using VISTAPHw software.

Narrative:
The state's hospital discharge database, Comprehensive Hospital Abstract Reporting System is the data source for this indicator. The rate is only for in-patient hospitalizations. The trend shows an overall significant decrease in the rate from 2000 to 2008.

Programs to prevent hospitalization for asthma include CHILD Profile/Immunizations (IPCP), Medical Home, Healthy Child Care Washington (HCCW), Early Childhood Comprehensive Systems (ECCS), promotion of Bright Futures and Early Periodic Screening, Diagnosis, and Treatment (EPSDT), and First Steps.

IPCP sends age-specific health information every 3-6 months to parents of children under six. Two mailings, Treating Childhood Emergencies and Illnesses and Protect Kids from Toxics, have asthma information. By promoting immunizations, IPCP helps control asthma by decreasing infectious disease and encouraging well-child visits.

Medical Home aims to ensure all children receive comprehensive, regular and coordinated health care. A medical home can give preventive health information via a primary provider, and provide specialty care for children with or at increased risk for asthma.

OMCH used an ECCS grant to help coordinate systems to improve health and health care in early childhood. We are also part of a multi-agency group to improve the use of EPSDT.

Bright Futures and EPSDT are best practices in well-child care. OMCH promotes both through HCCW, ECCS, and Medical Home. OMCH collaborates with other parts of DOH and other agencies to strengthen well-child care.

First Steps provides support and interventions for Medicaid mothers and newborns at risk for adverse outcomes during pregnancy and up to age one. Tobacco use is a program-targeted risk factor; providers work to reduce smoking by pregnant women and in the infants' homes. First Steps also prioritizes care for premature or low birth weight infants and those with congenital defects--all risks for asthma. First Steps had a 20% cut in state funds this state fiscal year.

OMCH coordinates with DOH's CDC-funded Asthma program, which implements the state asthma plan, reports on the state asthma burden, provides asthma education. It also maintains a statewide public-private group, the Washington Asthma Initiative (WAI) that works to improve the prevention, diagnosis and management of asthma by mobilizing individuals, organizations, and communities. WAI coordinates several local asthma coalitions that address local needs.

HCCW supports public health consultation in child care settings. This includes environmental health topics such as asthma/allergen prevention and proper cleaning. Most consultants are nurses who can give information on common childhood conditions. Asthma education is part of conferences and trainings for child care health consultants. Many also get specialized training in environmental health, for example the Healthy Homes training. The project will end in December 2010.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	99.1	99.0	99.1	98.8	98.9
Numerator	36986	38087	43527	45528	47878
Denominator	37322	38472	43923	46081	48410
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

These data are based on the Washington State 2009 Health Effectiveness Data and Information Set (HEDIS) Report from the Department of Social and Health Services and reflect the estimated statewide proportion of children who turned 15 months old during the reporting year, who were enrolled from 31 days of age in Medicaid or State Children's Health Insurance Program (SCHIP) and who received at least one well child visit. Data from seven managed care plans (who serve approximately 70% of the Medicaid enrollees less than 15 months) contributed to this report and are the source of the indicator percentage. Children not covered by managed care plans include those on Supplemental Securtiy Incoem (SSI), in foster care, and residents who live in counties without a managed care option.

Notes - 2008

These data are based on the Washington State 2008 HEDIS Report from the Department of Social and Health Services and reflect the estimated statewide proportion of children who turned 15 months old during the reporting year, who were enrolled from 31 days of age in Medicaid or SCHIP and who received at least one well child visit. Data from seven managed care plans (who serve approximately 70% of the Medicaid enrollees less than 15 months) contributed to this report and are the source of the indicator percentage. Children not covered by managed care

plans include those on SSI, in foster care, and residents who live in counties without a managed care option.

Notes - 2007
These data are based on the Washington State 2007 HEDIS Report from the Department of Social and Health Services and reflect the estimated statewide proportion of children who turned 15 months old during the reporting year, who were enrolled from 31 days of age in Medicaid or SCHIP and who received at least one well child visit. Data from seven managed care plans (who serve approximately 70% of the Medicaid enrollees less than 15 months) contributed to this report. Children not covered by managed care plans include those on SSI, in foster care, and residents who live in counties without a managed care option.

Narrative:
In 2009, 98.9% of Medicaid enrollees less than one year of age had at least one initial periodic screen. These data from the Department of Social and Health Services (DSHS) 2009 HEDIS Report show a very slight increase from last year's rate (98.8%), but still maintain the rate increase shown since 2000.

First Steps Maternity Support Services (MSS) providers serve about 70% of women eligible for Medicaid paid prenatal care and delivery. First Steps MSS providers assist women to identify a healthcare provider for their infant prior to delivery and support women for 2 months postpartum in keeping well child exams. Families eligible for Infant Case Management (ICM) continue to receive support, reinforcement and referrals.

OMCH seeks to improve the percent of Medicaid enrollees less than one year of age who received at least one initial periodic screen by supporting the Family Health hotline operated by WithinReach. The hotline refers parents to resources to help them enroll in and access Medicaid services for their children. In addition, First Steps MSS and ICM have worked with American Indian Health Commission to identify barriers to access for these services for Native Americans.

In 2009, eligibility to state subsidized insurance for children was increased to 300% of the federal poverty level. OMCH worked closely with DSHS, other state agencies, and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

In 2010, there was a 20% reduction to the First Steps budget. This decreased how many women were served.

The WithinReach ParentHelp123.org website is inviting and interactive. It helps families assess their eligibility for state benefit programs (including Medicaid and Food Stamps) and fill out applications on-line. This resource gives low-income families a single access point to free and low-cost health insurance, food assistance, and many other resources 24 hours a day. In 2009, over 37,000 people visited www.ParentHelp123.org and 11,000 families were screened for potential program eligibility using ParentHelp123's Benefit Finder. About 5,000 applications were completed.

The federal Early Childhood Comprehensive Systems Grant (ECCS) and Kids Matter, the partnership and strategic plan/framework developed through ECCS, identify Medical Home as a priority for all children aged 0-5 years. Kids Matter Awareness and Utilization surveys show a variety of state and local stakeholder activities being implemented related to this goal. Kids Matter partners and other OMCH staff participated in a new WithinReach project to assist parents and families access medical coverage and promote children receiving periodic health screens.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1	1	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are unavailable for 2009. We don't expect to be able to report on this measure for 2009 because data specific to SCHIP enrollees are not available through HEDIS for this age group. Washington SCHIP covers from 200 to 250% of the poverty level. In Washington, children are covered by SCHIP and Medicaid in much the same way. There is no reason to suspect a difference in levels of coverage.

Notes - 2008
Data are unavailable for 2008. We don't expect to be able to report on this measure for 2008 because data specific to SCHIP enrollees are not available through HEDIS for this age group. Washington SCHIP covers from 200 to 250% of the poverty level. In Washington, children are covered by SCHIP and Medicaid in much the same way. There is no reason to suspect a difference in levels of coverage.

Notes - 2007
Data are unavailable for 2007. We don't expect to be able to report on this measure for 2007 because data specific to SCHIP enrollees are not available through HEDIS for this age group. Washington SCHIP covers from 200 to 250% of the poverty level. In Washington, children are covered by SCHIP and Medicaid in much the same way. There is no reason to suspect a difference in levels of coverage.

Narrative:
In 2008 there were approximately 317 children less than 15 months of age covered by SCHIP, most of whom were enrolled in managed care plans. Their well-child experience is included in HEDIS, but because the enrollee numbers are so small, a separate estimate on the percent of SCHIP is not produced by HEDIS.

A seamless system called, Apple Health, covers all children in the state to 300% federal poverty level.

First Steps Maternity Support Services (MSS) and Infant Case Management (ICM) are administered by OMCH-MICAH through a contract with DSHS. One of their activities is to refer and link SCHIP eligible children to providers who offer periodic screening services, including immunizations and well-child care. In 2010, there was a 20% reduction to the First Steps budget. . This decreased the number Medicaid eligible women and infants who receive services beyond screening.

The ParentHelp123.org website, is run by a private non-profit organization, WithinReach, with partial funding from OMCH. ParentHelp123.org is inviting and interactive. It helps thousands of

families assess their potential eligibility for state benefit programs (including Medicaid and Food Stamps) and fill out program applications on-line. This web resource provides low-income families with a single access point to free and low-cost health insurance, food assistance, and many other resources--all in one place, 24 hours a day. In 2009, over 37,000 people visited www.ParentHelp123.org and 11,000 families were screened for potential program eligibility using ParentHelp123's Benefit Finder. About 5,000 applications were completed.

The federal Early Childhood Comprehensive Systems Grant (ECCS) and Kids Matter, the partnership and strategic plan/framework developed through ECCS, continue to identify Medical Home as a priority for all children aged 0-5 years. Kids Matter Awareness and Utilization surveys continue to show a variety of state and local stakeholder activities are being implemented related to this goal. Kids Matter partners and other representatives from OMCH participated in a new project from WithinReach that assists parents and families to access medical coverage, and promotes children receiving periodic health screens.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	68.0	66.3	64.8	65.5	
Numerator	43866	47222	49154	51181	
Denominator	64482	71244	75895	78167	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Birth data for 2009 are not yet available.

Notes - 2008
These data were obtained from the First Steps Database, Washington State Department of Social and Health Services, and are gathered from 2008 Washington State Birth Certificate files.

The numerator represents the number of resident women (ages 15-44) with a live birth whose Adequacy of Prenatal Care Utilization index is greater than or equal to 80%. The denominator represents all resident women (ages 15-44) with a live birth during the reporting year.

Notes - 2007
These data were obtained from the First Steps Database, Washington State Department of Social and Health Services, and are gathered from 2007 Washington State Birth Certificate files.

The numerator represents the number of resident women (ages 15-44) with a live birth whose Adequacy of Prenatal Care Utilization index is greater than or equal to 80%. The denominator represents all resident women (ages 15-44) with a live birth during the reporting year.

Narrative:

The Department of Social and Health Services (DSHS) First Steps Database (FSDB) 2008 data shows that approximately 65.5% of women scored 80% or higher on the Kotelchuck Index. This is a slight increase from last year's 64.8%. However, the overall trend since 1998 continues to be a statistically significant decrease of on average 1.1% per year in women who scored 80% or higher on the Kotelchuck Index. Over the last ten years, there has been a high percent of women, averaging about 22% per year, on whom we have insufficient data to calculate a Kotelchuck Index score. This should be taken into account when considering these data.

About 40% of all women (Medicaid and Non-Medicaid) who began prenatal care after the first trimester could not get care as early as they wanted (2006-2008 Washington Pregnancy Risk Assessment Monitoring Survey). Barriers included: not enough money/insurance to pay for care; not having a Medicaid or Healthy Options card or medical coupon (Medicaid women); unable to get a convenient appointment; keeping pregnancy secret; no way to get to clinic/doctor's office; child care unavailable; and doctor/clinic would not start as early as wanted.

In 2003, Washington adopted the 2003 revisions to the US standard birth certificate and changed how it collected data on entry to prenatal care. When other states adopted the revision varied, so these data are not comparable to earlier data, current US data, nor data from most other states.

In FFY 2009, 5,577 pregnant women called the WithinReach Family Health Hotline (FHH). Of these, 1,687 were already receiving prenatal care. Callers were given 7,010 related referrals (information about prenatal care and about benefit programs and accessing them).

First Steps Maternity Support Services (MSS) providers have served about 70% of women eligible for Medicaid paid prenatal care and delivery in recent years. MSS services promote early and continuous prenatal care for eligible women. DOH and DSHS are working on strategies to improve identification and referral of high risk pregnant Medicaid applicants. Statewide budget cuts will lower the number of women receiving services beyond screening in 2010.

DOH'S Center for Health Statistics (CHS) works with hospitals on completeness of birth record data. OMCH works with CHS on strategies to improve birth data quality, including prenatal entry and number of visits.

FSDB data show a decrease of 13% in the number of obstetric providers between 2001 and 2006. This is particularly acute for Family Practice physicians providing obstetric care.

WithinReach and DOH raised awareness of the value of prenatal care and availability of First Steps and other programs for pregnant women by enhancing information for pregnant women on ParentHelp123.org, implementing an on-line tool that helps pregnant women find First Steps providers, educating health care providers about WithinReach's services, and improving First Steps information on FHH.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.3	88.0	88.5	94.0	
Numerator	590014	593536	590175	675399	
Denominator	676232	674373	666834	718496	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data are not yet avaliable

Notes - 2008
Technical Note: The source of these data is the Client Services Database, Research Data and Analysis, Washington State Department of Social and Health Services; and Office of Financial Management. The numerator represents clients aged 1 to 21 years who are receiving medical assistance; it includes both managed care and fee for service clients. The data in the denominator are the total number of medically eligible clients aged 1 to 21 years old.

*SCHIP children are included in managed care
*Data is gathered from the Client Service Database, which does not get medical managed care encounter information. Therefore it does not measure the types of services received for children enrolled in managed care. Being enrolled in a managed care plan counts as receiving medical services, regardless of whether the child visited a health professional or not.

Notes - 2007
Technical Note: The source of these data is the Client Services Database, Research Data and Analysis, Washington State Department of Social and Health Services; and Office of Financial Management. The numerator represents clients aged 1 to 21 years who are receiving medical assistance; it includes both managed care and fee for service clients. The data in the denominator are the total number of medically eligible clients aged 1 to 21 years old.

*SCHIP children are included in managed care
*Data is gathered from the Client Service Database, which does not get medical managed care encounter information. Therefore it does not measure the types of services received for children enrolled in managed care. Being enrolled in a managed care plan counts as receiving medical services, regardless of whether the child visited a health professional or not.

Medically Eligible Title XIX description:
Clients who are eligible to receive medical services for which the state receives federal Title XIX matching funds. Title XIX of the Social Security Act funds:
(1) medical assistance on behalf of families with dependent children, whose income and resources are insufficient to meet the costs of necessary medical services, and of aged, blind, or disabled individuals.
(2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

Narrative:
For this year, due to personnel reductions at the Department of Social and Health Services (DSHS) Agency, data on the number of potentially Medicaid eligible children in Washington State who received a service paid for by the Medicaid Program in 2008 were not available. DSHS personnel indicated that the Client Services Database, from which these data have been supplied in the past, may be able to provide these data later in the Summer of 2010.

OMCH collaborated with the Washington State Department of Social and Health Services Medicaid Purchasing Administration (MPA) to develop a plan to increase the quality of and access to the Early Periodic Screening Diagnosis and Treatment program (EPSDT.) EPSDT provides well-child check-ups for children ages birth to 18 years. EPSDT improvement workgroups have been established to develop strategies for three specific areas of EPSDT

including: quality improvement; incentives for quality screening; health literacy and consumer education; and pilot projects. OMCH staff have partnered with MPA to lead and facilitate these workgroups. There may be increased work through EPSDT due to the Governor's focus on health insurance. OMCH is working closely with DSHS, other agencies, and stakeholders to increase enrollment of children to the newly expanded state subsidized insurance and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	56.5	57.0	59.1	60.3	62.4
Numerator	73259	76404	78397	81395	90495
Denominator	129672	133948	132761	134958	145127
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
These data come from the Washington State Department of Social and Health Services Medical Assistance Administration (MAA). The numerator represents the number of Medicaid enrolled children 6-9 who received any dental service in 2009. The denominator represents the total number of children ages 6-9 enrolled in Medicaid in 2009, in both Healthy Options (the MAA managed care program) and fee-for-service.

Notes - 2008
These data come from the Washington State Department of Social and Health Services Medical Assistance Administration (MAA). The numerator represents the number of Medicaid enrolled children 6-9 who received any dental service in 2008. The denominator represents the total number of children ages 6-9 enrolled in Medicaid in 2008, in both Healthy Options (the MAA managed care program) and fee-for-service.

Notes - 2007
These data come from the Washington State Department of Social and Health Services Medical Assistance Administration (MAA). The numerator represents the number of Medicaid enrolled children 6-9 who received any dental service in 2007. The denominator represents the total number of children ages 6-9 enrolled in Medicaid in 2007, in both Healthy Options (the MAA managed care program) and fee-for-service.

These data are provisional.

Narrative:
In 2009 the rate of Early and Periodic Screening, Diagnosis and Treatment (ESPDT) eligible children who received dental services was 62.4 %, an increase over 2008's rate of 60.3% and a continuation of the statistically significant trend to higher utilization seen since 2000. Over the past four years, data collection methodology has become consistent. Despite this, we do not yet have sufficient years of consistently compiled and comparable data to enable us to do a

meaningful trend analysis.

OMCH seeks to improve outcomes related to this measure through the following efforts: Kids Matter, a partnership and strategic plan/framework developed through the Early Childhood Comprehensive Systems (ECCS) grant, includes medical homes as one of the focus areas for promoting improvement and coordination in services for young children and their families. OMCH staff partner with other state agencies on an EPSDT Improvement Team to promote and improve access to and implementation of EPSDT across the state. The State Oral Health Program Manager participates in a national group to promote integration of medical and dental homes for all individuals (children and adults) in order to enhance the health system's effectiveness and patients' outcomes.

The Oral Health Program provides funding to local health jurisdictions (LHJs) to conduct community oral health assessment for oral health capacity and to develop coalitions and partnerships to improve local oral health capacity. LHJs also used the funding provide linkage and referral for children of all ages through its local oral health coordinators and for young children age 0-5 through several local Access to Baby and Child Dentistry (ABCD) programs. The new State Oral Health Referral Coordinator (funded by HRSA Grant 09-109) keeps an online directory of public clinics and Medicaid providers for each county to facilitate access to care. LHJs, other public programs, and the public actively use this directory, How to Find Dental Care at www.doh.wa.gov/cfh/oral_health/findcare.htm. The Referral Coordinator also seeks partnerships with other referral programs to make the referral process for the underserved more effective around the state.

In the future, OMCH staff will continue to work with partners to develop new strategies through the Bright Futures Guidelines work, Kids Matter, and EPSDT Improvement Team.

The Oral Health Program has also published the first Washington State Collaborative Oral Health Improvement Plan (funded by HRSA grant 08-134), which contains goals and objectives developed through partnerships with the private and public sectors and communities. This Plan includes strategies for increasing access to care for underserved populations.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.1	5.9	5.5	5.4	5.6
Numerator	875	897	860	749	810
Denominator	14300	15217	15720	13907	14537
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and the Federal Social Security Administration (SSA). The numerator is the unduplicated number of children under the age of 18 with a CHIF form completed indicating they

have SSI coverage in 2008. The age of 18 is used as SSA does not report numbers under age 16 separately. The denominator is from state-specific data from Children Receiving Supplemental Security Income (SSI), 2009. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payor of last resort.

Notes - 2008
The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and the Federal Social Security Administration (SSA). The numerator is the unduplicated number of children under the age of 18 with a CHIF form completed indicating they have SSI coverage in 2008. The age of 18 is used as SSA does not report numbers under age 16 separately. The denominator is from state-specific data from Children Receiving Supplemental Security Income (SSI), 2008. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payor of last resort.

Notes - 2007
The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and the Federal Social Security Administration (SSA). The numerator is the unduplicated number of children under the age of 18 with a CHIF form completed indicating they have SSI coverage in 2007 (860). The age of 18 is used as SSA does not report numbers under age 16 separately. The denominator is from state-specific data from Children Receiving SSI, 2007. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payor of last resort.

Narrative:
These data are gathered from the State Children with Special Health Care Needs Program's (CSHCN) Child Health Intake Form (CHIF). This is a program enrollment electronic form completed at local health jurisdictions and submitted to CSHCN quarterly. The number of state SSI beneficiaries who are less than 18 years old (SSA does not calculate data separately for 16 year olds) is calculated from the annual Children Receiving SSI report produced by the Social Security Administration (SSA). Data from 2009 indicate that approximately 5.6% of State SSI beneficiaries received rehabilitative services from CSHCN, which follows the decreasing trend in the rate seen over the past nine years, with an average annual decrease of 9.7% since 2000.

In Washington State the CSHCN focus is building systems of care, not providing or funding direct services. All children who are approved for SSI receive full Medicaid benefits. The benefits package provides unlimited therapies to children. The CSHCN program works closely with the state Medicaid agency to assure access to these services. Local CSHCN programs assist families in applying for appropriate benefits, including SSI and Medicaid. Our target is purposefully low to reflect the service system in the state. CSHCN continues to be involved with the Medicaid agency to provide input on policies and rules regarding benefits, billing and reimbursement. CSHCN created and continues to support a system of regular regional and statewide meetings to provide ongoing discussion regarding barriers and opportunities for children with special needs, including health coverage benefits. Regular attendees in these meetings include the state Medicaid agency, other state agencies, health plans, family organizations and a variety of providers.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

MCH populations in the State					
Percent of low birth weight (< 2,500 grams)	2008	matching data files	6.6	6.1	6.3

Narrative:
In 2008 the non-Medicaid birth rate was 6.1% and the Medicaid birth rate 6.6%. While both Medicaid and non-Medicaid women show a similar trend toward a higher percent of low birth weight babies, the increase in non-Medicaid women is more pronounced with an average annual increase of 2% since 1998, while Medicaid women experienced a 0.5% increase over the same time period.

These data come from the First Steps Database (FSDB), which links Medicaid claims data with birth and fetal death certificates annually. OMCH collaborates with DSHS and communities to plan and implement strategies for improvement where indicated.

These data show that Medicaid recipients have higher proportions of low birth weight than do non-Medicaid recipients. However, since 1990 the Medicaid singleton low birth weight rate has remained stable, while the non-Medicaid singleton low birth weight rate has increased.

First Steps Maternity Support Services (MSS) providers have served about 70% of women eligible for Medicaid paid prenatal care and delivery in recent years. MSS targets Medicaid eligible pregnant women who are at highest risk for low birth weight, to promote healthy birth outcomes. Statewide budget reductions will decrease the number of women who receive services beyond screening in 2010.

Unintended variations in the cesarean, vaginal birth after cesarean (VBAC), and induction rates are affecting maternal and infant health, including low birth weight. OMCH's Maternal, Infant, Child, and Adolescent Health section (MICAH), DSHS and community partners have convened a Perinatal Advisory Committee (PAC) sub-committee to address these issues. This subcommittee meets monthly to review the literature for best practices and to make decisions about efforts to improve quality in maternity and infant care. The committee is making recommendations to community providers and agencies on how to improve safety, patient choices, and efficacy of cesarean sections and VBACs.

OMCH publishes an annual Perinatal Indicators Report that provides information about selected indicators, health status, and behaviors of pregnant and postpartum Medicaid and non-Medicaid women.

The OMCH, Assessment section regularly updates the MCH Data and Services Report and provides data and information about related services associated with this HSCI in order to guide future decision-making.

The state PAC, staffed by MICAH, meets three times per year with professional healthcare organizations such as March of Dimes, and Washington State chapters of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists. PAC identifies and prioritizes new and emerging statewide perinatal concerns and makes recommendations through workgroups that address perinatal issues. These issues include services and outcomes for Medicaid and non-Medicaid women and their newborns. PAC provides consultation and recommends prioritized solutions to DOH and DSHS.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2007	matching data files	6.4	3.5	4.9

Narrative:
These data come from the First Steps Database (FSDB), which links Medicaid claims data with birth and fetal death certificates annually. FSDB, housed at the Washington State Department of Social and Health Services (DSHS), produces a number of reports on pregnancy and newborn health indicators. OMCH collaborates with DSHS and communities to plan and implement strategies for improvement where indicated.

These data show that Medicaid recipients have higher proportions of infant deaths than do non-Medicaid recipients. The small numbers in the numerator of this indicator make the rate somewhat unstable and therefore trends harder to identify. Both Medicaid and non-Medicaid women have experienced a decrease in infant deaths since 1998. The Medicaid population has experienced the greater decrease with an average annual decrease of just over 2%, while the non-Medicaid population's decreased by 1.6% over the same time period. The decrease in the Medicaid population is a statistically significant trend. The trend in the non-Medicaid population is not statistically significant, however.

The state Perinatal Advisory Committee (PAC), staffed by Maternal, Infant, Child, and Adolescent Health (MICAH), meets three times per year with professional healthcare organizations such as March of Dimes, and Washington State chapters of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists. PAC identifies and prioritizes new and emerging statewide perinatal concerns and makes recommendations through workgroups that address perinatal issues, including services and outcomes for Medicaid and non-Medicaid women and their newborns. PAC provides consultation and recommends prioritized solutions to DOH and DSHS.

The Perinatal Regional Network, Washington State's regionalized perinatal program, uses state and federal funds to coordinate and implement state and regional quality improvement projects to decrease poor pregnancy outcomes for which Medicaid clients are at disproportionately increased risk. These projects often assess healthcare access for pregnant women and newborns and compare Medicaid vs. non-Medicaid data.

In 2008 Washington State received a seven year grant from the Bill & Melinda Gates Foundation to conduct a ground-breaking campaign to prevent infant deaths due to unsafe sleep practices. Of the more than 4,500 sudden, unexpected infant deaths occurring each year in the United States, experts estimate that at least 50 percent could be prevented by placing babies to sleep in a safe environment. The campaign, Bedtime Basics for Babies, combines a crib distribution component for families in need with a wide-spread public and professional education component to demonstrate its effectiveness at influencing infant sleeping practices and saving infant lives.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	matching data files	66.6	87	77.1

Notes - 2011
These data come from a diferent source, the First Steps Database, WA State Department of Social and Health Services, than do the data reported in NPM 18 which are from birth certificate data prepared by the WA Center for Health Statistics.

Narrative:
In 2008, 77.1% of pregnant women began care during the first trimester. For women in Medicaid, the rate was 66.6%, compared to non-Medicaid at 87.0%. The unknown rates are: non-Medicaid 8.1% and Medicaid 5.9%. While both Medicaid and non-Medicaid women show a similar trend toward fewer receiving care beginning in the first trimester, the decline in Medicaid women is more pronounced with an average annual decrease of 1.2% since 1999 while non-Medicaid women experienced a 0.6% decrease over the same time period.

These data come from the First Steps Database (FSDB), which links Medicaid claims data with birth and fetal death certificates annually. FSDB, housed at the Washington State Department of Social and Health Services (DSHS), produces a number of reports on pregnancy and newborn health indicators. OMCH collaborates with DSHS and communities to plan and implement strategies for improvement where indicated.

These data show that Medicaid recipients are less likely to receive first trimester prenatal care than non-Medicaid recipients.

First Steps Maternity Support Services (MSS) providers have served about 70% of women eligible for Medicaid paid prenatal care and delivery in recent years. MSS provides services to promote early and continuous prenatal care for Medicaid eligible pregnant women. Statewide budget reductions will decrease the number of women who receive services beyond screening in 2010.

The WithinReach Family Health Hotline (FHH) referred pregnant women to benefit programs including Medicaid and provided information about prenatal care services. During this period 5,577 pregnant women called the FHH. Of these callers, 1,687 were already receiving prenatal care.

In Pierce County, a contractor provides outreach to First Steps eligible pregnant women and women of child bearing age, with an emphasis on reaching African American women. The contractor works with church leaders, identified as trusted members of the community, to improve referrals to First Steps. They also network and provide outreach to community groups that address health issues for communities of color.

MICAH works with the American Indian Health Commission to address the disparities that exist among pregnant American Indian/Alaska Native women including access to prenatal care.

Since 2003, data from FSDB show an overall decrease in the number of obstetric providers from 2003 to 2006. That report shows that overall the number of obstetric providers decreased by 13%

between 2001 and 2006. The decrease is particularly acute for Family Practice physicians who provide obstetric care.

Due to declining resources and H1N1 activities we have not been able to focus on this issue as a priority over the past year.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	matching data files	58.6	71.9	65.5

Narrative:
For 2008 the overall rate for adequate prenatal care was 65.5%, for Medicaid women, 58.6%, and for non-Medicaid it was 71.9%. The percent of births that were unknown were Medicaid 11% and non-Medicaid 12.9%. Both Medicaid and non-Medicaid populations have experienced a downward trend in the percent of women with adequate prenatal care since 1998. The trends are about equal in magnitude with the Medicaid population experiencing an average annual decrease of 0.9% and the non-Medicaid population's average annual decrease over the same time span being 1%.

These data are from the Department of Social and Health Services (DSHS) First Steps Database (FSDB).

One major health indicator tracked by OMCH is the percent of pregnant women with adequate prenatal care (observed or expected prenatal visits are greater than or equal to 80% of the Kotelchuck index): These data show Medicaid recipients are less likely to receive adequate prenatal care, than non-Medicaid recipients. OMCH's efforts to improve this indicator include First Steps Maternity Support Services (MSS) activities and data monitoring, analysis, and publication. Maternal, Infant, Child, and Adolescent Health (MICAH) also worked with specific communities where the disparity between Medicaid and non-Medicaid first trimester entry into prenatal care was greater than the state average. We are identifying specific systems barriers to address this issue. MICAH also worked to improve the quality and completeness of birth certificate filing data to improve our ability to assess prenatal care entry and adequacy. In a state-wide quality improvement project, contractors worked with targeted hospitals to increase the completeness of the prenatal data on the birth filing record, targeting the date of first prenatal care, pre-pregnancy height and weight, and date of last menses.

MSS providers served about 70% of women eligible for Medicaid paid prenatal care and delivery in recent years. MSS provides services to promote early and continuous prenatal care for Medicaid eligible pregnant women. In 2010 statewide budget reductions significantly reduced access to these programs.

The WithinReach Family Health Hotline (FHH) referred pregnant women to benefit programs including Medicaid and provided information about prenatal care services. During this period, 5,577 pregnant women called the FHH and received 7,010 referrals. Of these callers, 1,687 were already in prenatal care.

In Pierce County, a contractor does outreach to First Steps eligible pregnant women and women of child bearing age, particularly African American women. The contractor works with church leaders, who are trusted community members, to improve referrals to First Steps. They also network and provide outreach to community groups addressing health issues in communities of color.

MICAH works with the American Indian Health Commission to address the disparities among pregnant American Indian/Alaska Native women including access to prenatal care.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	300

Narrative:
Eligibility to state subsidized insurance for children was increased to 300% of the federal poverty level (FPL) in 2009. OMCH is working closely with the Washington State Department of Social and Health Services, other agencies and stakeholders to increase enrollment of children through outreach to prospective families; and to increase access through enhanced provider reimbursement for services and improvements in quality indicators. State budget reductions have decreased resources for outreach.

The First Steps program referred Medicaid eligible infants to the Apple Health Program, the Washington State SCHIP.

WithinReach's Family Health Hotline (FHH) and Apple Health for Kids Hotline referred families with children to benefit programs including Medicaid and SCHIP and provided information about children's health and services for children. During this period 11,335 callers with children called the FHH and 9,518 called the Apple Health for Kids Hotline.

DOH is working with state and local partners to improve developmental screening throughout the state for children birth to school entry.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's**	**YEAR**	**PERCENT OF POVERTY LEVEL**

Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2008	300

Narrative:
Eligibility to state subsidized insurance for children was increased to 300% of the federal poverty level (FPL) in 2009. OMCH is working closely with the Washington State Department of Social and Health Services, other agencies, and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators. State budget reductions have decreased resources for outreach.

The First Steps program referred Medicaid eligible children to the Apple Health Program, which is the Washington State SCHIP. The Apple Health Program plans to decrease outreach efforts for 2010 due to state budget reductions.

WithinReach's Family Health Hotline (FHH) and Apple Health for Kids Hotline referred families with children to benefit programs including Medicaid and SCHIP and provided information about children's health and services for children. During this period 11,335 callers with children called the FHH and 9,518 called the Apple Health for Kids Hotline.

DOH is working with state and local partners to improve developmental screening throughout the state for children birth to school entry.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	

Notes - 2011
SCHIP eligibility open to children only.

Narrative:

Medicaid is used to cover expenses of pregnant women in Washington State up to185% of the federal poverty level (FPL). Eligibility to state subsidized insurance for children is up to 300% FPL. The First Steps program refers Medicaid eligible pregnant teens to the Apple Health Program, which is the Washington State SCHIP.

According to the First Steps Database, Medicaid paid for 47.8% of the births in Washington State in 2008.

OMCH is working closely with the Washington State Department of Social and Health Services, other agencies, and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

WithinReach's Family Health Hotline (FHH) and Apple Health for Kids Hotline referred families with children to benefit programs including Medicaid and SCHIP and provided information about children's health and services for children. During this period 11,335 callers with children called FHH and 9,518 called the Apple Health for Kids Hotline.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	1	Yes
Survey of recent mothers at least every two years (like	3	Yes

PRAMS)		

Notes - 2011

Narrative:
Access to data from other programs and agencies is built from gaining the trust from these programs and agencies. OMCH, especially MCH Assessment, works to gain and maintain that trust. MCH Assessment maintains access to analytic data files and up-to-date documentation for: vital statistics, hospital discharge data, linked vital statistics and hospital discharge data, Pregnancy Risk Assessment Monitoring System data, Healthy Youth Survey, Behavioral Risk Factor Surveillance data, National Immunization Survey, National Survey of Children's Health, National Survey of Children with Special Needs, and in-house survey data. These data are used extensively for reports and presentations within OMCH, DOH and with external stakeholders to promote the use of data to inform policy discussions and program planning. In addition, the MCH Assessment manager participates on the Assessment Operations Group which is a cross-agency group dedicated to communication among epidemiologists and assessment staff across the DOH. The group meets monthly and discusses analytic guidelines, methodology, surveys in the field, data-sharing, ethics, confidentiality, data security and IRB-related concerns, and potential collaborations.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	1	No
Healthy Youth Survey	3	Yes

Notes - 2011

Narrative:
There are two major factors that influence the OMCH's ability to maintain and/or improve this indicator. First, the Tobacco Settlement Fund has been critical to Washington's ability to capture data on smoking behaviors among school students. Every two years, Washington conducts the Healthy Youth Survey (HYS), which gathers information about behaviors among public school students. The HYS is the principal manner in which the state of Washington collects data on its adolescent population regarding a variety of health behaviors. For most of the state, data from the HYS are available at the school district level. The HYS has been given every other year to students in the 6th, 8th, 10th, and 12th grades.

In 2008 the HYS reported that there was a significant decrease in cigarette smoking among 6th graders from 1995 to 2008 from 4% to 1%. For 12th graders there was a significant increase in cigarette smoking from 1990 to 1999, 21% to 35%, but the trend then reversed itself from 1999 to 2008, from 35% to 20%. For reported chewing tobacco use, the rates for both 8th and 10th grade students significantly decreased from 1995 to 2008. For 8th grade there was a decrease from 12% to 3% and for 10th grade a decrease from 15% to 7%.

The Tobacco Settlement Fund contributes approximately one third of the operational costs of the survey. Second, the HYS is led by a multi-agency workgroup. OMCH works with other state agencies and external stakeholders to develop questions for the HYS. The ability of this workgroup to resolve issues that cross agency boundaries has been instrumental in the on-going political support the survey has maintained.

DOH's tobacco prevention funds were cut more than 40% during the most recent legislative session. HYS funding support from Tobacco was cut in half for the HYS 2010 survey and is not expected to be available for the HYS 2012 survey, as the Tobacco prevention program itself is slated for elimination by then.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Office of Maternal and Child Health (OMCH) built the 2010 Needs Assessment (NA) process on the results of its 2005 Needs Assessment. In the early stages of the 2010 Needs Assessment, we reviewed the priorities identified in the 2005 process with OMCH leadership and with internal and external stakeholders. Their input affirmed that the priorities are still valid and provide a strong foundation for improving outcomes in maternal and child health. The priorities are:

1. Adequate nutrition and physical activity
2. Lifestyles free of substance use and addiction
3. Optimal mental health and healthy relationships
4. Health equity
5. Safe and healthy communities
6. Healthy physical growth and cognitive development
7. Sexually responsible and healthy adolescents and women
8. Access to preventive and treatment services for the maternal and child population
9. Quality screening, identification, intervention and care

Since the priorities are very broad, we initially asked stakeholders to define and choose among sub-priorities that drill down separately into each of OMCH's nine priorities. Our goal was to have more focused and concrete sub-priorities to help frame Office and program objectives. However, midway through the 2010 NA process, another significant state budget cut was proposed. This proposal continued a trend OMCH has experienced in both federal and state funding over the last few years. At the same time, there was a proposal from the Governor and legislators for the Department of Health (DOH) to reorganize OMCH services. We realized a mid-course shift in the 2010 NA process was prudent.

Given the budgetary and policy changes OMCH is experiencing and anticipates over the next several years, we refocused the Needs Assessment on identifying and enhancing core strategies that cross the nine priorities rather than defining sub-priorities that drill down into each of the nine priorities separately. These cross priority strategies will focus on the Infrastructure and Population-Based Services levels of the pyramid. For example, stakeholders consulted in the 2010 NA process valued the work that OMCH does in convening people to develop strategies and solve problems. Our work on a universal developmental screening process is a good example of OMCH's convening a range of stakeholders to work on a strategy that crosses priorities. We will seek other strategies and interventions that cross priority areas in their impact.

Concurrent with the 2010 Needs Assessment, the Division of Community and Family Health, which OMCH is part of, began a strategic planning process. The strategic planning is driven by similar budget and policy factors that impacted the 2010 Needs Assessment process. The strategic planning process is seeking new efficiencies across Offices and new ways to integrate work. For example, OMCH is looking at the life course approach as a better ways to prioritize its work. At the same time, the Office Community and Wellness Prevention, which manages the chronic disease programs, is moving away from disease management toward more prevention efforts. These two changes provide an opportunity for the two offices to better integrate their work.

OMCH's efforts in the area of preconception are a good example of our using the life course approach. Preconception care aims to improve reproductive outcomes by promoting and improving the health of women prior to and in between pregnancies. We knew that focusing on preconception would be a challenge given Washington's unintended pregnancy rate. This rate has remained constant and close to 50% for many years. In 2006, we used focus groups of reproductive age women and of health care providers to get a better understanding of perspectives and behaviors regarding healthy living and the use of primary care services. The

results informed our strategies for addressing preconception issues. They lead us to develop health promotion messages that imbed factors promoting preconception health into overall healthy living messages for women of reproductive ages. These messages are now included in DOH birth control brochures, in health promotion material for WIC clients, and in a newly developed DOH women's health web page. In addition, WithinReach, the non-profit organization, operating the state's toll-free Family Health Hotline incorporated healthy living messages into telephone conversations with callers and its interactive website to connect families with children with essential services and resources, including health promotion information. We have also partnered with the state Department of Corrections, Medicaid, and other state agencies to provide appropriate health education messages and linkages to community resources to female inmates transitioning out of prison.

In most cases, the needs reflected in the 2010-2014 priorities are more pronounced than they were in previous years due to significant budget reductions and increased economic hardship statewide. In some cases, like Healthy Child Care Washington, program funding has been completely eliminated at the federal and state levels. MCH Block Grant reductions most significantly impact National Performance Measures 3 and 4 and State Performance Measures 5 and 6. Results of budget cuts are described in the performance measure narratives.

OMCH's work on national and state performance measures are described in the next two sections, C. National Performance Measures, and D. State Performance Measures. In the 2009 application and 2007 annual report, Washington introduced three new performance measures. They are process measures intended, over time, to lead to outcome measures aligned with the MCH priorities. We have been successful in using the process measures to develop three new state performance measures aligned with MCH priorities in the areas of optimal mental health and healthy relationships, health equity, quality screening, identification , intervention and care.

After the 2005 Needs Assessment, staff developed issue briefs that clearly describe our focus, objective, and expectations for each priority. We will update the issue briefs to reflect the life course approach and opportunities to work across the nine priorities. Our goal is to include updated issue briefs in the 2012 Block Grant Application and 2010 Report.

B. State Priorities

2005 - 2009 OMCH Priorities

The following summarizes the relationship between Washington State Office of Maternal and Child Health's (OMCH) nine priority needs and the current state performance measures, national performance measures, outcome measures, health systems capacity indicators, and health status indicators for the 2005-2009 Priorities.

This crosswalk tool reflects current state performance measures as of July, 2010.

Adequate nutrition and physical activity
NPM 11, 15
OM 1-5
SPM 07
HSCI 5, 9a
HSI 1a-b, 2a-b

Lifestyles free of substance use and addiction
NPM 10, 15
OM 1-5
SPM 08
HSCI 1, 9b

HSI 1a-b, 2a-b, 3a-c, 4a-c

Optimal mental health and healthy relationships
NPM02, 6, 11, 16
OM 6
SPM 09
HSCI 4

Health Equity
OM 2
SPM 10

Safe and healthy communities
HSCI 1
NPM 10, 16
OM 6
SPM 08, 9
HSI 3a-c, 4a-c

Healthy physical growth and cognitive development
NPM 06, 11, 12
SPM 07, 8, 9

Sexually responsible and healthy adolescents and women
NPM 08, 18
SPM 01, 8, 9
HSCI 4
HSI 5a-b

Access to preventive and treatment services for the MCH population
NPM 03-7, 9, 12-14, 17-18
OM 1-5
SPM 01, 6, 7, 10
HSCI 3-8

Quality Screening, identification, intervention, and care coordination for the MCH population
NPM 1-3, 5-7, 9, 12, 17, 18
OM 1-5
SPM 06, 8, 10
HSCI 2-5, 7

2010 - 2014 OMCH Priorities

As part of the 2010 Five Year Needs Assessment, OMCH reaffirmed that the nine priority needs first identified in the 2005 Needs Assessment are still valid. The following summarizes the relationship between Washington State OMCH's nine priorities and the new state performance measures, the national performance measures, outcome measures, health systems capacity indicators and health status indicators for the 2010-2014 Priorities.

This crosswalk tool reflects new state performance measures that Washington will report on starting with the 2012 Block Grant Application/2010 Report.

Adequate nutrition and physical activity
NPM 11, 15
OM 1-5

New SPM 04
HSCI 5, 9a
HSI 1a-b, 2a-b

Lifestyles free of substance use and addiction
NPM 10, 15
OM 1-5
New SPM 07
HSCI 1, 9b
HSI 1a-b, 2a-b, 3a-c, 4a-c

Optimal mental health and healthy relationships
NPM02, 6, 11, 16
OM 6
New SPM 05
HSCI 4

Health Equity
OM 2
New SPM 06, 7

Safe and healthy communities
HSCI 1
NPM 10, 16
OM 6
New SPM 04, 5, 7
HSI 3a-c, 4a-c

Healthy physical growth and cognitive development
NPM 06, 11, 12
New SPM 04, 5

Sexually responsible and healthy adolescents and women
NPM 08, 18
New SPM 01
HSCI 4
HSI 5a-b

Access to preventive and treatment services for the MCH population
NPM 03-7, 9, 12-14, 17-18
OM 1-5
New SPM 02, 4, 7
HSCI 3-8

Quality Screening, identification, intervention, and care coordination for the MCH population
NPM 1-3, 5-7, 9, 12, 17, 18
OM 1-5
New SPM 02, 3, 4, 7
HSCI 2-5, 7

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	95	100	100	100	100
Annual Indicator	100.0	98.9	100.0	99.2	
Numerator	99	91	89	125	
Denominator	99	92	89	126	
Data Source				WA Newborn Screening Program	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Data not available.

Notes - 2008
PERFORMANCE OBJECTIVES: The Newborn Screening program expects to maintain 100% of screen positive newborns receiving timely follow up. Therefore, for the period of 2008-2014, the future objectives will be 100%.

The percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, hemoglobinapathies, and congenital adrenal hyperplasia with appropriate referral. Over time laboratory cutoffs have been adjusted for some conditions to decrease the detection of infants with conditions that are NOT clinically significant and don't require treatment.

These data come from the WA Newborn Screening Program and are the same as reported in Form 6. The numerator is the number of live births in Washington that were reported by the Office of Newborn Screening as screened and were a confirmed case that received timely follow up. The denominator is the number that were screened and were a confirmed case. In 2008, 99.2% of newborns received a newborn screening (86,058 of 86,718). Excluded from the denominator were births in military hospitals (3,365), refusals (92), neo-natal deaths (127) and a small number tested by the State of Oregon (16). Washington State currently screens for PKU, congenital hypothyroidism, galactosemia, sickle cell disease, congenital adrenal hyperplasia, MCAD deficiency, biotinidase, maple syrup urine disease (MSUD), homocystinuria and Cystic Fibrosis. See Form 6 for details on screening for each condition.

Notes - 2007
PERFORMANCE OBJECTIVES: The Newborn Screening program expects to maintain 100% of screen positive newborns receiving timely follow up. Therefore, for the period of 2008-2013, the future objectives will be 100%.

The percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, hemoglobinapathies, and congenital adrenal hyperplasia with appropriate

referral. Over time laboratory cutoffs have been adjusted for some conditions to decrease the detection of infants with conditions that are NOT clinically significant and don't require treatment.

These data come from Form 6. The numerator is the number of live births in Washington that were reported by the Office of Newborn Screening as screened and were a confirmed case that received timely follow up. The denominator is the number that were screened and were a confirmed case. In 2007, 99.2% of newborns received a newborn screening (84,925 of 85,641). Excluded from the denominator were births in military hospitals (3,077), refusals (48), neo-natal deaths (157) and a small number tested by the State of Oregon (21). Washington State currently screens for PKU, congenital hypothyroidism, galactosemia, sickle cell disease, congenital adrenal hyperplasia, MCAD deficiency, biotinidase, maple syrup urine disease (MSUD), homocystinuria and Cystic Fibrosis. See Form 6 for details on conditions.

a. Last Year's Accomplishments
Washington met its target. One home birth was not submitted for screening on time

The Newborn Screening laboratory (NBS) began its IRB approved study with the University of Washington (UW) Biochemical Genetics Clinic to evaluate an approach to detecting lysosomal storage diseases in infants through newborn screening. This work, supported by a National Institutes of Health (NIH) grant, uses anonymous specimens that are residual to required screening. The study began screening for one of the lysosomal storage diseases, Fabry. It has expanded to include mucopolysaccharidosis (MPS) type 1 and Pompe. When we find a sample with an abnormal result, we submit it to the UW for genetic testing of the disorder.

NBS completed its part of a collaborative project with researchers from the Pacific Northwest Research Institute. The project's purpose is to investigate type 1 diabetes (also known as juvenile, or insulin dependent diabetes) as part of The Environmental Determinates of Diabetes in the Young (TEDDY) study. This study is being funded through an NIH grant and is part of a large multi-center, multi-national prospective study to look for environmental triggers of type 1 diabetes. The study recruited participants from newborns with high-risk genetic profiles. If parents consented to participate in the study, we provided the researchers a small sample of leftover blood from the child's newborn screening specimen.

NBS also completed its part of 1) a research study with University of Washington, Seattle Children's, and Fred Hutchinson Cancer Research Medical Center looking at the relationship between cytomegalovirus in an infant's blood and development of hearing loss, and 2) a research study with the UW looking at correlations between mother's smoking level as reported on the birth certificate and levels of cotinine (a nicotine metabolite) in dried blood spots.
Now that NBS has four years experience screening for cystic fibrosis (CF), we have carefully compared our IRT/IRT method with the more typical IRT/DNA method used by other states. The evaluation compares sensitivity and specificity. We developed internal protocols to detect false negative results, as CF screening does not have the typical detection performance of other screening tests. These efforts included, but are not limited to, a yearly cross-check of cases identified by NBS with the four CF centers we make referrals to. We have also added DNA analysis for the single most common CF mutation (DF508) as a modification to our screening algorithm for low birth weight (LBW) babies. About 8% of newborns are LBW. With this approach, we have reduced the impact of screening on these babies and developed a fast and reasonably priced way to improve the IRT/IRT method.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Ensure that all screen positive infants receive timely diagnosis and, if needed, are enrolled in long-term clinical management.				X
2. Perform screening tests for all mandated conditions on approximately 170,000 specimens.			X	
3. Follow-up to assure that appropriate diagnostic and clinical services are provided in response to screening test results.			X	
4. Contract with pediatric specialists and comprehensive care clinics to provide expert diagnostic and treatment services for infants with abnormal screening results.				X
5. Update and develop new professional and lay educational information for distribution: websites, provider manuals, on-site hospital visits, disorder-specific fact sheets and pamphlets, etc.				X
6. Determine family eligibility for financial and support services and coordinate through state and county Children with Special Health Care Needs programs (CSHCN) and medical homes.		X		
7. Purchase and distribute medically necessary formulas and low-protein foods for individuals with PKU and other metabolic disorders.		X		
8. Collect long-term outcome data to evaluate the benefit of various components of treatment, compliance, and intervention.				X
9. Continue to work with researchers to evaluate potential screening tests for other treatable childhood disorders; currently lysosomal storage diseases.				X
10.				

b. Current Activities

The Newborn Screening (NBS) Program continues to ensure that all screen positive infants receive timely diagnosis and, if needed, are enrolled in clinical management. In 2009, we screened 166,037 specimens from 85,058 infants. We detected disorders in 125 of the infants. Seventy-three infants screened positive for congenital hyperthyroidism; 14, for cystic fibrosis; and 13 for hemoglobinopathies. We also found six infants with amino acid disorders and six with fatty acid oxidation disorders. Finally, we found five other conditions in four or fewer infants each. Those conditions are congenital adrenal hyperplasia, galactosemia, and organic acid disorders.

In addition to the children above, we identified 1,162 infants with hemoglobin patterns that are not clinically significant, but likely helpful for the parents and providers to be aware of. Examples are sickle cell trait which was found in 421 infants, and alpha thalassemia which was found in 183 infants.

c. Plan for the Coming Year

On January 21, 2010, the national Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC) voted unanimously to add screening for Severe Combined Immune Deficiency (SCID) -- commonly known as bubble boy disease -- to the core panel for universal screening of all newborns in the United States. Babies with SCID appear healthy at birth. Without early treatment, most often by bone marrow transplant from a healthy donor, these infants cannot survive. We have reviewed the ACHDNC's excellent work and believe there is a compelling case for adding SCID screening. DOH leadership agreed to recommend to Washington State Board of Health add SCID to the state's screening panel. Key DOH players including NBS staff will meet with the Board of Health staff to make a formal recommendation to add SCID to the existing panel of 27 mandated conditions. If approved, the formal process to amend the law will be initiated. We will also have to develop a strategy for adding SCID to the screening panel. If all goes smoothly, we expect newborn screening for SCID will be implemented in the summer of 2011.

We will work closely with the pediatric immunology group at Seattle Children's Hospital and UW, who are very supportive of newborn screening. We are confident that they can provide excellent treatment care for infants detected through screening.
The NBS Laboratory will continue refining the lab method for detection of three lysosomal storage diseases in infants through newborn screening as described in the past and current year's activities. There should be sufficient data to show whether or not the method has a high enough sensitivity and specificity to be a test suitable for universal newborn screening.
The NBS Program will continue to make quality improvements. Three main areas of focus are:
1. Reduction in transit time from the submitters at hospitals and clinics for specimens to reach NBS for analysis. This has become more critical as some of the metabolic disorders on our screening panel are life-threatening in the first week of life.
2. Re-evaluating our screening algorithms to increase sensitivity (that all true positives are recognized) as well as specificity (with few false positives)
3. Long-term follow-up of children with the disorders detected to ensure that the proper systems are in place for optimal clinical management and support for families.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**86718**					
Reporting Year:	**2008**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	86058	99.2	6	3	3	100.0
Congenital Hypothyroidism (Classical)	86058	99.2	133	83	83	100.0
Galactosemia (Classical)	86058	99.2	2	0	0	
Sickle Cell Disease	86058	99.2	9	9	9	100.0
Biotinidase Deficiency	86058	99.2	0	0	0	
Cystic Fibrosis	86058	99.2	48	16	16	100.0
Homocystinuria	86058	99.2	4	0	0	
Maple Syrup Urine Disease	86058	99.2	2	2	1	50.0
21-Hydroxylase Deficient Congenital Adrenal	86058	99.2	72	8	8	100.0

Hyperplasia						
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	86058	99.2	7	5	5	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	56	56.5	57	55.7	55.7
Annual Indicator	54.9	54.9	55.7	55.7	55.7
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55.7	55.7	55.7	55.7	55.7

Notes - 2009
Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Annual performance objective falls within the 95% confidence interval of the current rate. In 2007, following the release of the most recent survey, discussions with program staff led to the target of 55.7% to be established through 2014.

Data come from survey and state numerator/denominator are not available.

Notes - 2008
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Annual performance objective falls within the 95% confidence interval of the current rate. In 2007, following the release of the most recent survey, discussions with program staff led to the taget of 55.7% to be established through 2013.

Data come from survey and state numerator/denominator are not avaliable

Notes - 2007
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Annual performance objective falls within the 95% confidence interval of the current rate.

a. Last Year's Accomplishments
Data for this measure originate from the National Survey of Children with Special Health Care Needs. We used data from 2001 and 2005/06 surveys. We did not examine trends as there are only 2 data points available.

Washington met its target for this measure. To assure family partnerships, the CSHCN program recruited family advisors to actively participate in CSHCN regional meetings, Medical Home Leadership Network (MHLN) teams, Communication Network meetings, Family To Family Health Information Center, MCH Block Grant review, Medical Home strategic planning and other activities. A family advisor from a local Parent to Parent Program attended the national Association of Maternal and Child Health Programs (AMCHP) as a Family Mentor. Family advisors were also active in MCH Region X, and Family Voices Region X.

To promote family leadership, the CSHCN Program contracted with
Seattle Children's Hospital to conduct "Teaching Through Stories" curriculum. They assisted parents participating in community forums and medical home teams. The Family as Advisors Toolkit was updated and shared with parent leaders statewide.

CSHCN obtained families' input on the National Performance Measures. CSHCN completed the MCH Family and Consumer Involvement Survey. The results were used to inform methods to support family and consumer involvement across OMCH.

To promote and support family involvement, the CSHCN Program contracted with Parent to Parent Program www.arcwa.org , Fathers' Network www.fathersnetwork.org., and WithinReach, http://withinreachwa.org/.
Input obtained through MCH Block Grant training and review sessions, Medical Home Leadership Network (MHLN) team parents, epilepsy and oral health grant parent and youth advisors, and Washington Family to Family Network, was used to inform the Families as Decision Makers/ Family Professional Partnership Strategic Plan. (Fig 4a, NPM02, Act 1)

The CSHCN contracted with the UW to support families' involvement in the community feeding teams.
To assure families' partnership, the CSHCN shared a fact sheet on Family-Professional Partnerships. with various partners through meetings, distribution and website. CSHCN also has recruited parents to work with the Oral Health Program for the development of the oral health fact sheets and curricula for children with special needs with minor to moderate chronic conditions.

The CSHCN Program hired a new Family Involvement Coordinator to conduct the following activities for two federal grants, Epilepsy and Autism Project. Accomplishments are shown below:
1. Epilepsy/Autism Projects. Recruited parents, providers, and other professionals to attend state and national learning collaborative meetings and summits to learn and share ideas about epilepsy and autism. 2. Employed a Family Involvement Coordinator who provided leadership for inclusion of the family perspective in policy and program development for children and youth with special needs. 3. Supported partnerships through contracts such as the University of Washington's Medical Home and Adolescent Health Transition Projects, the Center for Children with Special Needs at Seattle Children's, and parent support organizations. Funded Children with Special Health Care Needs Coordinators at LHJs to link families to appropriate information and referral services in their local communities to medical homes. Ensuring coordinated systems of care for families are in place in their local communities. 4. Shared information and resources to partners including parents through meetings and Epilepsy website http://www.doh.wa.gov/cfh/mch/Epilepsy/Default.htm and Autism website http://www.doh.wa.gov/cfh/mch/Autism/Autism.htm.
Through the Epilepsy Project, ethnic outreach coordinators worked with parents with children with epilepsy and seizure disorders in our target communities attending a National Learning Collaborative. The purpose was to obtain their input, promote the use of care organizers and

encourage them to adopt the use of seizure action plans to communicate with the child's medical providers and school nurses.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide ongoing analysis of data on children with special needs, including family involvement data. Sources: National Survey of Children with Special Health Care Needs, National Survey of Children's Health, and various Washington State data source				X
2. Ensure family representation in policy development through Medical Home Leadership Network, local health jurisdictions, Autism and Epilepsy projects, Washington Family to Family Network partnership and ongoing dialogue at CSHCN Communication Net.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Through a contract with Seattle Children's, we are reviewing three leadership curricula and a web-based Story Network for parents to share their experiences.

Through contracts with partners, family advisors, youth and parents continue to participate in various meetings and activities. Meetings include the CSHCN Communication Network meetings, MCH Block Grant review, MCH Region X, and AMCHP. CSHCN pursues opportunities to provide Title V family leadership training, family advocacy and support resources, and family consultant tips and tools for parents and youth.

The CSHCN Program shares the fact sheet on Family-Professional Partnerships.

The CSHCN Program continued implementing two federal Epilepsy and Autism grants. Activities related to family involvement in both projects are listed below:

1. Recruiting parents to attend state and national learning collaborative meetings and summits. 2. Having a Family Involvement Coordinator on staff who provides leadership for inclusion of the family perspective in policy and program development. 3. Supporting partnerships through contracts.

Parents of children and youth with epilepsy are reviewing the current seizure action plan. The goal is to update the form to work with all types of seizures rather than just the more emergent ones. Nursing Consultant/Care Coordinators in target communities are also gathering information from parents on their experience using the care organizer.

c. Plan for the Coming Year

To promote families' partnership the CSHCN Program will continue to contract with Seattle Children's to develop and provide trainings to increase the skills and knowledge related to group facilitation for parent leaders. The WA State Parent to Parent Coordinator will provide input on the trainings and assist in assuring the Parent to Parent County leads can facilitate groups of families

and youth successfully.

CSHCN Program will continue to use the fact sheet to promote family-professional partnerships to ensure that a family participates as a partner in decision-making with professionals at all levels in their child's care and that the family is satisfied with all health services that child receives.

Care organizers and Seizure Action plans will be promoted in 6 more counties in which parent support organizations have ethnic outreach coordinator. We will support fathers with children and youth with epilepsy in 18 counties through a contract with the Father's Network. Parents of children with Epilepsy will continue providing feedback in the use of the communication tools, family support, and other educational materials received.

The CSHCN Program will continue to ensure family representation throughout the state through contracts with the University of Washington Medical Home Leadership Network, local health jurisdictions, Washington State Parent to Parent, Washington State Fathers Network, WithinReach, and others. Family advisors and partners will continue to participate in various meetings and conferences. They will include the CSHCN Communication Network meetings, MCH Block Grant review, MCH Region X, Infant Early Childhood Conference, Duncan Seminar and AMCHP. CSHCN will pursue opportunities to provide Title V family leadership training, family advocacy and support resources, and family consultant tips and tools for parents and youth.

CSHCN will increase collaboration with Family to Family Health Information Center by attending Health Navigator trainings. CSHCN will continue to include culturally diverse family members on the Combating Autism Advisory Council. We will continue to use the expertise of the family members on the council to review and edit publications developed through the autism grant. CSHCN will continue to research funding opportunities to have material translated into multiple languages. The CSHCN Program will continue to distribute Centers for Disease Control and Prevention Learn the Signs: Act Early material to early learning centers throughout the state. We will continue to partner with Parent to Parent and Fathers Network to promote the Epilepsy grant material to additional areas of the state with Hispanic communities.

CSHCN will continue to contract with the U W to support parents' involvement in community-based feeding teams (Fig 4a, NPM02, Act 2)

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	53	53	53	48.6	48.7
Annual Indicator	53.6	53.6	48.3	48.3	48.3
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	48.8	48.9	49	49.1	49.1

Notes - 2009
Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM03. A new annual performance objective of 48.5% was developed in 2007 based on discussion with program staff. An annual increase of 0.1 was chosen, and has been extended through 2014.

Data come from survey and state numerator/denominator are not avaliable

Notes - 2008
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM03. A new annual performance objective of 48.5% was developed in 2007 based on discussion with program staff. An annual increase of 0.1% was chosen, and has been extended through 2013.

Notes - 2007
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM03. A new annual performance objective of 48.5% was developed based on discussion with program staff. An annual increase of 0.1% was chosen through 2012.

a. Last Year's Accomplishments
Data for this measure originate from the National Survey of Children with Special Health Care Needs. We used data from 2001 and 2005/06 surveys. We did not examine trends since only 2 data points are available.

CSHCN met the target for this measure. MCH Assessment and the CSHCN Program developed a care coordination data monograph and a Medical Home fact sheet. The information was shared with stakeholders to bring up the importance of care coordination and medical home. CSHCN Program contracted with the University of Washington (UW) Medical Home Project to support the Medical Home Leadership Network (MHLN), Medical Home website www.medicalhome.org, and increase awareness of medical home activities statewide.

The CSHCN Program and UW Medical Home contractors worked with Medical Home learning collaboratives to plan and implement legislation on medical homes. (Fig 4a, NPM03, Act 2).

The CSHCN Program contracted with local health jurisdictions (LHJs) to increase awareness of, access to, and staff participation in medical homes within their communities. Accomplishments included providing ongoing information to CSHCN Coordinators and families about connecting children to medical homes and participating on medical homes as part of the MHLN. (Fig 4a, NPM03, Act 3)

The CSHCN Program promoted the medical home concept through strategic planning, including

promotion of medical homes through epilepsy and autism grant activities and work on committees to improve reimbursement for activities related to medical homes and care coordination. The program also led the DOH Medical Home Partnership Committee, a forum for other state agencies and private entities to share statewide activities related to medical home.

We promoted the medical home concept with CSHCN Nutrition Network dietitians. CSHCN Program integrated training and activities through the UW contracts. The CSHCN Family Involvement Coordinator worked with Medical Home to increase family- professional partnerships at the local practice level.
Working with the Oral Health Program, the CSHCN Program promoted the medical home and dental home concepts to providers and families.
CSHCN funded care coordination for four Maxillofacial Review Boards, all of whom provide family-centered care and assure all children seen by the Boards have a medical home.
The CSHCN Program promoted partnerships among families, health care providers, other professionals, agencies and communities to help families learn about and access medical and other services for their children with special needs.
The CSHCN obtained federal funds for Epilepsy and Autism grants. Accomplishment included:

1. The Epilepsy and Autism Projects promoted medical homes through care coordination and co-management strategies, and developed educational materials, use of care notebooks, care plan tools, and other resources through these two federal grants. 2. Supported contracts such as the University of Washington's Medical Home and Adolescent Health Transition Projects, the Center for Children with Special Needs at Seattle Children's, parent support organizations, and other partners to develop and maintain websites and resources related to medical homes. 3. Promoted the CSHCN Coordinators' involvement in medical homes in their local communities. 4. Supported new legislation to promote medical homes for all children and improve reimbursement for care within a medical home.
Epilepsia en Washington worked with the UW Regional Epilepsy Center, School Nurse Administrators, and Seattle Children's Hospital to ensure that families with children with epilepsy/seizures had medical homes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide ongoing analysis of data on children with special needs, including family involvement data. Sources: National Survey of Children with Special Health Care Needs, National Survey of Children's Health, and various Washington State data source				X
2. Contract with the Medical Home Leadership Network to support the Medical Home website, increase awareness of medical homes statewide and build the Medical Home Leadership Network.				X
3. Contract with local health jurisdictions for activities that increase awareness of, access to, and staff participation in medical homes within their communities.		X		
4. Provide leadership to spread the medical home concept through strategic planning.		X		
5. Implement the Epilepsy/Autism/Early Childhood Comprehensive Systems Grants to promote medical homes for children and youth with epilepsy.				X
6.				
7.				

8.				
9.				
10.				

b. Current Activities

CSHCN Program works with developmental pediatricians and state agencies to improve developmental screening by convening a Developmental Screening Partnership Committee to give statewide partners input on a plan to implement universal screening. The program provides leadership on medical homes for children with special health care needs to the DOH medical home learning collaborative and for statewide activities related to Medical Home.

Through contracts and collaboration with UW, LHJs and other partners, the CSHCN Program conducts activities that increase awareness of, access to, and staff participation in medical homes in Washington. Activities include providing ongoing information to CSHCN Coordinators and families about connecting children to medical homes; participating on medical homes as part of the MHLN; distributing a medical home care plan and a medical fact sheet; supporting new legislation to promote medical homes and improving reimbursement for components of care within a medical home.

The CSHCN Program is revising the Medical Home Strategic Plan to incorporate elements of the autism and epilepsy grants, assuring all children are connected to a medical home.

The CSHCN Family Involvement Coordinator works with Medical Home to increase family-professional partnerships at the local practice level. The Epilepsy and Autism grants include efforts to increase access to culturally competent family-centered medical homes.

c. Plan for the Coming Year

We have a broad plan for the coming year to build infrastructure and enable services. It includes:

The CSHCN Program will refine and implement a state plan to promote universal developmental screening in response to needs identified through the CSHCN Autism grant and MICAH Project LAUNCH grant.

CSHCN Program will continue to contract with LHJs for activities that increase awareness of, access to, and staff participation in medical homes within their communities. This will include providing ongoing information to CSHCN Coordinators and families about connecting children to medical homes and participating on medical home teams as part of the MHLN.

We will encourage family advisors to be part of each MHLN team. To document the effectiveness of their work in providing care coordination as part of a medical home in their communities, CSHCN Coordinators will pilot methods of collecting outcomes related to the Omaha System pathways, Health Care Supervision and Communication with Community Resources.

Four new Child Health Notes will be developed and distributed to MHLN based on feedback from a survey conducted during the current year. Medical Home website resources will be updated to reflect the changing environment for medical home and compliment the medical home collaborative activities through DOH.

CSHCN will participate and provide the voice of children and families to the medical home collaborative activities. The Medical Home Strategic Plan will have ongoing implementation efforts, including reaching new audiences. CSHCN will participate in the DOH Patient Centered Medical Home Collaborative.

CSHCN will continue a contract with the UW to integrate, CSHCN Nutrition Network dietitians and Washington feeding teams with the MHLN.

CSHCN Program will continue to work for children and youth with special health care needs in Washington to receive coordinated, ongoing, comprehensive care within a medical home using a

fact sheet and other state data sources. We will participate on interagency workgroups to expand medical homes for all children covered by Apple Health.
The CSHCN Program will continue working with neurology centers, school nurse administrators, and family support organizations to ensure that families with children with epilepsy/seizures have medical homes.
CSHCN will contract with the UW to strengthen family representatives in their role on the MHLN teams, identify areas where they want technical assistance, problem solve and share successful strategies with each other, and provide family input to the MHLN project. This contract will also work with P2P, Fathers Network and other family organizations to identify local parents interested in collaborating with MHLN teams to expand their autism activities.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	63	64.5	66	67.5	69
Annual Indicator	64.4	64.4	65.3	65.3	65.3
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70.5	72	73.5	75	76.5

Notes - 2009
Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. The most recent data are from the 2005-2006 survey. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Based on discussion with program staff an annual increase of 1.5 was chosen starting in 2007 and extended through 2014.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

Data for this measure originate from the National Survey of Children with Special Health Care Needs (NS-CSHCN). We used data from 2001 and 2005/06 surveys. We did not examine trends as there are only 2 data points available.

The data comes from the NS-CSCHN last collected in 2007 and will not be collected again for two more years.

To provide information and build infrastructure, MCH Assessment and CSHCN reviewed data from the NS-CSHCN, to measure progress in health coverage for children with special needs. (Fig 4a, NPM04, Act 1)

CSHCN staff and MCH Assessment staff did further analysis, made presentations and developed documents such as fact sheets and issue briefs using NS-CSHCN data for Washington. We explored other data sources for applicable information on children and youth with special needs in our state. (Fig 4a, NPM04, Act 1)

The CSHCN program reviewed annual Child Health Intake Form (CHIF) client data on third-party payment sources. Through the Strategic Software Services contract, CSHCN supported local health jurisdiction (LHJ) staff use of this data system. (Fig 4a, NPM04, Act 2)

Continued improvements were made to data collection for the CHIF, the form local CSHCN programs use to provide statewide data on children served by Title V in the state. CSHCN staff reviewed and analyzed the data submitted to identify children who have insurance as well as the types of insurance and other funding they rely on for services.

The CSHCN Program worked closely with the Department of Social and Health Services, Medicaid Purchasing Administration on outreach and quality assurance activities for Apple Health, formerly called Cover All Kids. Apple Health includes all health care coverage using state and federal Medicaid and SCHIP funds for Washington children up to 300% FPL. CSHCN shared the information on Apple Health with families participating in support groups, nursing consultants/care coordinators and CSHCN coordinators, and providers who work with children and their families. CSHCN worked with interagency committees to help define components of care within a medical home and how they could be reimbursable for Medicaid providers.

Many partners, including health plans, attended the quarterly CSHCN Communication Network meetings. The group routinely discussed access and financial coverage issues to improve care for children with special health care needs. CSHCN continued to interface with the Office of the Insurance Commissioner and share resources with families and partners about the Insurance Consumer Hotline.

The CSHCN Nutrition Consultant completed the annual Formula Fund Usage report and worked closely with the state Medicaid agency, the Newborn Screening Program, and WIC to ensure coverage for therapeutic formulas.

CSHCN worked with the MCH Oral Health Program, the state Medicaid agency and insurance companies to ensure adequate oral health coverage for children with special health care needs. (Fig 4a, NPM04, Act 3)

CSHCN Program contracted with Sacred Heart Children's Hospital to improve nutrition access for children with special health care needs in Eastern Washington.

We provided nutrition reimbursement information to certified dietitians to assure nutrition services in the region.

CSHCN consulted with the WithinReach Family Health Hotline and web-based ParentHelp123. In July 2007,funding to WithinReach was reduced due to reductions in the MCH Block Grant to

Washington State. It has not been restored.

CSHCN worked with the Family to Family Health Information Center/Family Voices, Parent to Parent, and Fathers Network to develop strategies for health insurance access. (Fig 4a, NPM04, Act 3)

CSHCN successfully tracked expenditures for diagnostic and treatment funds to ensure projected needs were met and expenditures were within available funding limits. (Fig 4a, NPM04, Act 4)
CSHCN provided limited funding for medically necessary diagnostic and treatment services not covered by other sources. We did this through the CSHCN Coordinators to assist clients in their communities. (Fig 4a, NPM04, Act 4)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide ongoing analysis of data on children with special needs, including family involvement data. Sources: National Survey of Children with Special Health Care Needs, National Survey of Children's Health, and various Washington State data sources.				X
2. Collect and analyze statewide program information from Child Health Intake Form (CHIF) and Health Service Authorizations to identify children who have insurance.				X
3. Collaborate through various interagency forums such as Communication Network, Medicaid Integration Team, the Washington Family to Family Health Information Center (Family Voices) and interactions with managed care plans.				X
4. Provide limited diagnostic and treatment funds to fill gaps in medically necessary services for children with no or inadequate coverage.		X		
5. Work with Washington State Department of Social and Health Services, Medicaid Purchasing Administration on outreach and quality assurance activities for Cover All Kids.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
We share information about medical coverage and health reform through the CSHCN Communication Network, CSHCN staff and MCH Regional Teams meetings. Collaboration with health plans focuses on patient education and outreach strategies.
CSHCN works with partners to ensure coverage for therapeutic formulas and oral health services.
CSHCN is working with a new state partner to focus on foster children with complex medical needs.
OMCH staff do data analysis to identify children with insurance and the types of insurance and other funding sources they have. The data sources include NS-CSHCN 2005-2006, NSCH 2007 data and the Child Health Intake Form (CHIF). The CHIF data provide information on children with special health care needs served by Title V in Washington. We do data training and quality improvement on CHIF through a Strategic Software Services contract . Through the federal autism grant, CSHCN is identifying issues and policies that need improvements for children with autism and other developmental disabilities.

CSHCN provides limited funding for medically necessary diagnostic and treatment services not covered by other sources. CSHCN monitors whether expenditures stay within funding limits. Nursing consultants/care coordinators and CSHCN coordinators provide information on adequate health insurance coverage to identified parents of CSHCN, especially those with children with epilepsy/seizure disorder.

c. Plan for the Coming Year

To provide information and build infrastructure to meet the NPM 04 target, we will do the activities below.

The statewide Communication Network will meet quarterly to inform partners, share information about policies affecting children with special needs and their families, and collectively solve access issues.

The CSHCN section will invite HRSA staff to the CSHCN staff meeting quarterly to deal with specific health coverage issues and to ensure CSHCN staff is aware of the most current information about publicly funded health coverage. CSHCN will work with Washington Family to Family Health Information Center, Family Voices, Parent to Parent, Fathers Network, and other family partners to identify gaps in financing, help families navigate systems of care, and enhance communication between families and providers.

CSHCN staff will participate in the AMCHP Board, Title XIX Advisory Committee and other interagency workgroups to consider health care reform and implement policies that impact benefit packages and provider reimbursement for enhanced services for children including those with special health care needs, like autism.
CSHCN will work with a new partner, Fostering Well-Being at DSHS, to focus on foster children with complex medical needs and coordination of benefits. CSHCN will work with the Office of the Insurance Commissioner on a publication on benefits for youth transitioning to adulthood and on referring families with insurance issues to the Insurance Consumer Hotline.

CSHCN and MCH Assessment staff will do analysis, make presentations and develop documents like fact sheets and issue briefs. We will improve data collection through CHIF. CSHCN staff will review and analyze the data submitted to identify children with insurance and the types of insurance and other funding they rely on for services. Through the Strategic Software Services contract, the CSHCN Program will provide support to LHJ staff to improve reporting and use of their data.

The CSHCN Program will work with the state Medicaid agency, the Newborn Screening Program, and WIC to ensure coverage for therapeutic formulas.
Care coordinators and CSHCN Coordinators will provide information about adequate health insurance to newly identified families in one-on-one meetings and through support groups.

To assure formula coverage, CSHCN Nutrition Consultant will write the annual formula fund report and work closely with Medicaid Purchase Administration, Newborn Screening and the WIC Program. CSHCN will contract with UW and Sacred Heart Children's Hospital to assure information on coverage for Medical Nutrition Therapy and formula is shared with registered dietitians in Washington.

CSHCN will provide limited funding for medically necessary diagnostic and treatment services not covered by other sources. CSHCN will track and project expenditures to meet these needs.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	74.6	75	76	85.5	85.6
Annual Indicator	74.1	74.1	85.4	85.4	85.4
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	85.7	85.8	85.9	86	86.1

Notes - 2009
Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM05. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1 was chosen through 2014.

Notes - 2008
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM05. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1% was chosen through 2013.

Notes - 2007
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM05. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1% was chosen through 2012.

a. Last Year's Accomplishments
Data for this measure originate from the National Survey of Children with Special Health Care Needs. We used data from 2001 and 2005/06 surveys. We did not examine trends as there are only 2 data points available.

Last year's target for this measure was met. Below are last year's accomplishments:

The CSHCN Assessment Coordinator worked closely with MCH Assessment to provide analysis of available data on children with special needs age 0-17 years. Data sources included NS-CSHCN, the NS-Children's Health and other Washington State sources. Efforts focused on children whose families reported community-based service systems were organized for easy use. (Fig 4a, NPM05, Act 1). CSHCN staff reviewed data from the NS-CSHCN, 2005-06 about community systems. (Fig 4a, NPM05, Act. 1)

CSHCN contracted with Seattle Children's to revise the online resource directory www.cshcn.org. This revision allowed improved availability of resource information on child care, respite, audiology, and other identified needs. Resources were also developed for families of children with epilepsy and autism.
The CSHCN Nursing Consultant visited each CSHCN Region to survey CSHCN Coordinators. The product was recommendations on prioritizing activities to benefit clients and providers. CSHCN Coordinators completed a logic model outlining their activities based on the CSHCN national performance measures. (Fig 4a, NPM05, Act 3)

CSHCN Program provided information to assist families in finding resources. We made the information available to families, agencies, and organizations, both on line and in hard copy.

The CSHCN program encouraged families attending UW Regional Epilepsy Center, Seattle Children's Hospital, and parent support organizations and Educational Service Districts in targeted grant communities to use care organizers and seizure action plans. The Epilepsy Foundation Northwest, Local Health Jurisdictions (LHJs) and other family support organizations provided families with children with epilepsy/seizures with information and materials that could facilitate their access to health care services.

CSHCN contracted with UW to support the nutrition website
http://depts.washington.edu/cshcnnut/ for the community-based feeding teams and the CSHCN Nutrition Network in Washington State. (Fig 4a, NPM05, Act 3)

CSHCN contracted with Sacred Heart Children's Hospital to share nutrition resources with children, their families and providers through the website
http://www.shmcchildren.org/index.pp/services/95, meetings and other outreach activities.

The CSHCN Program, together with state, community, and family partners, promoted community-based services which were accessible, coordinated, family-centered, and culturally competent. Accomplishments for Epilepsy and Autism grants included:

1. Distributed Epilepsy Care Organizers and Autism Guidebook for Washington State.
2. Promoted the development of family-professional partnerships at the community level.
3. Promoted the Coordinators' involvement in activities that link families to appropriate services in their local communities through contracts.
4. Developed tips and tools for families on Medical Home Leadership Network, Adolescent Health Transition Project, the Center for Children with Special Needs, and CSHCN Program's websites.

CSHCN contracted with 16 neurodevelopmental centers (NDCs) to support community infrastructure to deliver early intervention services in a medical home model using state funds for 2009-2011. (Fig 4a, NPM05, Act 4)
Through Maxillofacial contracts with Seattle-King County, Mary Bridge Hospital, Yakima Valley Memorial Hospital and Spokane Regional Health District, the CSHCN Program supported community infrastructure and services for children with cleft lips, cleft palate and other facial anomalies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide ongoing analysis of data on children with special needs, including family involvement data. Sources: National Survey of Children with Special Health Care Needs, National Survey of Children's Health, and various Washington State data sources				X
2. Develop and implement strategies around community care coordination using the WISE pilot outcome evaluation, and information from the National Epilepsy Learning Collaborative and other organizations.			X	
3. Maintain network of CSHCN Coordinators and interagency collaborations to provide forums for system improvement that include families as partners; and provide learning opportunities about local, state and national systems for CSHCN.				X
4. Contract with Neurodevelopmental Centers (NDCs) to support community-based collaborations.				X
5. Assure and promote community-based service system through autism and epilepsy grants and contracts with University of Washington, Seattle Children's, Sacred Heart Children's Hospital, local health and others.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

We are evaluating the distribution plan for resources to assure more families and providers have access to these resources. We are developing resources for families of children with epilepsy and autism to add to Starting Point. A "Prescription Pad" tool is under development for providers to give families. CSHCN program is meeting with contractors to assure multiple web-based resources for Washington's children with special needs are linked and duplication is avoided. This will streamline access families have to web-based resources.

OMCH provides analysis of available data on children with special needs whose families report the community-based service systems are organized so they can use them easily.

UW Regional Epilepsy Center, Seattle Children's, schools, local health districts, and family support organizations continue to identify families with children with epilepsy/seizures and provide them information about local resources.
15 NDCs are receiving a base amount of state funding. One of the original 16 centers closed because of core funding reductions from a variety of sources.

CSHCN is working with agency partners to resolve Home Health Licensing issues impacting the provision of early intervention services for children birth to three in natural environments.
CSHCN is working with a new state partner to focus on foster children with complex medical needs and coordination of care locally.

c. Plan for the Coming Year

The CSHCN Program, working with partners, will promote community-based services. The plan for the coming year includes:

CSHCN will share information and resources to broader audiences including local chapters of physician and nurse practitioner associations serving children.
We will distribute Care Organizers and Care Notebooks more widely when requested by providers and families. The "Prescription Pad" resource for providers will be distributed to members of the Medical Home Leadership Network and other providers and promoted through the WA Chapter American Academy of Pediatricians and the WA Association Family Physicians.

CSHCN Program will provide ongoing orientation to new CSHCN Coordinators and partner with other community care coordinators such as school nurses and early intervention to assure families and children get the comprehensive services they need.

CSHCN will contract with UW and Sacred Heart for nutrition training and resource sharing activities.

The CSHCN Program will continue contracts with 15 NDCs and 4 Maxillofacial teams. We will mentor a new center to help it potentially be fundable in the next grant cycle. To award state funding for 2011-2013, we will conduct a competitive state grant process for early intervention centers meeting the state NDC definition.

The CSHCN Program, with state, community, and family partners, will promote community-based services that are accessible, coordinated, family-centered and culturally competent. Activities will include: improving autism services by grant funding care coordination; coordinating with WithinReach and the Early Support for Infants and Toddlers Program to enhance a statewide information and referral line responding to questions about developmental screening; promoting CSHCN Coordinators involvement in activities linking families to appropriate services, resources, and information in their local communities.

CSHCN will use the quarterly Communication Network meetings as a forum to improve community service systems with state and regional partners.

CSHCN will collaborate on local care coordination with the state agency that focuses on foster children with complex medical needs.

Through their websites, Seattle Children's Hospital and the Epilepsy Foundation Northwest will host electronic copies of the resources developed and additional information on support for families.
We will conduct the following activities to assure and promote community-based services for individuals with autism. We will:
1. Promote the Autism Guidebook.
2. Promote the development of family-professional partnerships at the community level.
3. Promote the CSHCN coordinators' involvement in activities that link families to appropriate services in their local communities through contract.
4. Develop tips and tools for families on Medical Home Leadership Network, Adolescent Health Transition Project, Center for Children with Special Needs and Washington State Department of Health CSHCN Program's websites.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	8.3	9.8	11.3	47.4	47.5
Annual Indicator	5.8	5.8	47.3	47.3	47.3
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	47.6	47.7	47.8	47.9	48

Notes - 2009
Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the small sample size. The data for the two surveys are not comparable for NPM06 and the 2005-2006 survey may be considered baseline data. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1 starting in 2009 was chosen through 2014.

Notes - 2008
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for NPM06 and the 2005-2006 survey may be considered baseline data. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1% was chosen through 2013.

Notes - 2007
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for NPM06 and the 2005-2006 survey may be considered baseline data. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1% was chosen through 2012.

a. Last Year's Accomplishments
Data for this measure originate from the National Survey of Children with Special Health Care Needs (NS-CSHCN). We used data from 2001 and 2005/06 surveys. We did not examine trends as there are only 2 data points available.

Washington met its expectations for improving transition services for youth with special health care needs. Activities were focused on sharing information among providers, youth and their

families to improve infrastructure in Washington. Accomplishment included the following:
CSHCN contracted with the University of Washington (UW) Adolescent Health Transition Project (AHTP) to provide information about transition from federal, state, and community programs and services. AHTP maintained the AHTP website depts.washington.edu/heathtr and collaborated with groups such as providers, schools, families and agencies interested in improving the health care system to transition youth with special needs from pediatric to adult providers. The AHTP promoted adolescent transition materials with an emphasis on school nurses, CSHCN Coordinators, families, providers, and other community partners. (Fig 4a, NPM06, Act 1)
The AHTP also participated in a work group convened by CSHCN Program staff to review the 5 Year Strategic Plan to identify and prioritize tools and resources appropriate for adolescent health transition for providers and families of youth with special health care needs. It also identified ways to follow through on the Adolescent Transition Resource Notebook revisions to enhance its usefulness and family-friendliness.

CSHCN shared the Results of the Primary Care Provider (PCP) Survey through presentations and reports with a Special Interest Group. We then used the survey to develop tools to help providers bring youth with special needs into their practices.
CSHCN shared information and promoted the materials developed by the AHTP about adolescent transition with OMCH's Maternal, Infant, Child and Adolescent Health (MICAH) section, the Office of the Superintendent of Public Instruction, the Epilepsy Learning Collaborative, Division of Developmental Disability and Division of Vocational Rehabilitation to enhance transition services and access to them. CSHCN worked with MCH Assessment to provide analysis of available data, including the NS-CSHCN 2005-2006 on adolescents with special needs, the Washington State Healthy Youth Survey, the Child Health Intake Form (CHIF) and other data sources. (Fig 4a, NPM06, Act 3)

CSHCN completed a Fact Sheet on Adolescent Transition to Adult Life. We developed it to provide information on how the CSHCN Program, along with a variety of partners, worked to help families and youth in the state receive the services necessary to make transitions to adult life, including adult health care, work and independence. Activities included improving coordinated transition from pediatric to adult care providers through Epilepsy/Autism federal grants, involving youth and families in Advisory Councils, and efforts to increase the disability content in educational curricula for nurses, doctors, and dentists.
CSHCN contracted with the Center for Children with Special Needs (CCSN) at Seattle Children's to support an interactive webpage on CSHCN.org, based on the Adolescent "Time Away from Home" Module. We provided links to a contact person at Epilepsy Foundation Northwest to assist adolescents with special health care needs (transition to adult health care) and promote self-management.

CCSN also assisted adolescents in self-management skills by promoting teen care plans. CCSN collaborated with adolescents who have chronic conditions, to develop a video for posting on You-Tube. The video promotes the use of teen care plan templates. CCSN provided education to youth and families for health transition by developing and piloting an educational program for adolescents and families to address pertinent transition topics. Topics included adult health care culture, insurance, self-management, "letting go", and "moving on". Based on pilot results, CCSN identified ways this program could be implemented for youth and their families through the DOH-CSHCN Epilepsy Grant. It promoted the program to community organizations, parent organizations and other hospitals.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Contract with the University of Washington, Adolescent Health				X

Transition Project and Center for Children with Special Needs at Seattle Children's to provide transition information about federal, state, and community programs and services.				
2. Partner with public and private agencies/organizations to enhance transitions.				X
3. Provide ongoing analysis of data on adolescents with special needs, including family involvement data. Sources: National Survey of Children with Special Health Care Needs, Washington State Healthy Youth Survey, and other data sources.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN contracts with the UW AHTP to maintain the AHTP website and continue collaborating with providers, schools, families and agencies. The AHTP is building capacity of School Nurses and School Nurse Corp Administrators to include health transition in the Individualized Education Plans (IEP) for young adults. In addition, work continues incorporate revisions recommended by the CSHCN Program into the AHTP Notebook. (Fig 4a, NPM06, Act 1.)

CSHCN shares information and promotes a Fact Sheet on Transition to Adult Life and materials developed by the AHTP about adolescent transition with the MICAH section, the Office of the Superintendent of Public Instruction, the Epilepsy Learning Collaborative, Division of Developmental Disability and Division of Vocational Rehabilitation to enhance transition services and access to them. CSHCN works with MCH Assessment to provide analysis of available data, including the NS-CSHCN, 2005-2006, National Survey of Children's Health (NSCH) 2007, CHIF, the Washington State Healthy Youth Survey and other data sources. (Fig 4a, NPM06, Act 3)

The CCSN at Seattle Children's works on strategies to obtain feedback to better understand the information needs of our statewide audience, including teens; supports and promotes electronic access to information via www.CSHCN.org for teens; and provides education to youth for health transition.

c. Plan for the Coming Year

Washington will continue the following activities to build infrastructure services for youth with special health care needs receiving transition services. The plan for the coming year includes the following:

CSHCN will share information and promote the materials developed by the AHTP about adolescent transition with the MICAH section, the Office of the Superintendent of Public Instruction, the Epilepsy Learning Collaborative, Division of Developmental Disabilities and Division of Vocational Rehabilitation to enhance transition services and access to them. CSHCN will work with MCH Assessment to provide analysis of available data, including the NS-CSHCN 2005-2006, NSCH 2007, the PCP Survey, Washington State Healthy Youth Survey and other data sources. (Fig 4a, NPM06, Act 3)

CSHCN Program, through the Autism Project and a variety of partners, will work to help families and youth in the state receive the services necessary to make transitions to adult life, including adult health care, work and independence.

CSHCN will contract with the University of Washington Adolescent Health Transition Project (AHTP) to provide information about transition from federal, state, and community programs and services and for maintenance of the AHTP website. AHTP will continue collaborating with Seattle University Center for Change in Transition Services and others to build capacity of School Nurses and School Nurse Corp Administrators to include health transition in the IEP for young adults. AHTP will develop a White Paper as a discussion tool to work with school nurses on moving the Health/IEP/School Nurse role information forward. In addition, work will continue on the AHTP Notebook, including revisions recommended by CSHCN.

To improve the website usability experience for teens, CSHCN will contract with the Center for Children with Special Needs (CCSN) at Seattle Children's to support and promote electronic access to information via CSHCN.org and Facebook. The Center will
draft new content/web pages: Preparing for Milestones and Transitions (e.g. dating, graduation, leaving home); Transitioning to Adult Health Care (e.g., preparing for differences between pediatric and adult health care, health insurance basic, finding a new provider) and create a Transitioning to Adult Health Care Video. CCSN will also develop an online "Am I Ready?" quiz, conduct a Usability Test with Teens, and provide two educational programs for teens and parents on transition issues. At least one of these programs will be outside the Seattle King County area. Finally, CSSN will promote these resources to community organizations, parent organizations and other hospitals.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77	78	79	79	80
Annual Indicator	77.8	77.6	73.9	77.7	
Numerator	62309	64358	62089	65960	
Denominator	80089	82935	84017	84891	
Data Source				National Immunization Survey	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	80	80	80	80

Notes - 2009
Data from 2009 NIS not yet available.

Notes - 2008
PERFORMANCE OBJECTIVES: Discussion with Immunization staff led to the decision to set the annual performance objective equal to the Healty People 2010 goal of 80 percent coverage for these antigens. The survey point estimate's 95% confidence interval of +/- 5.3% (72.4%, 83.0%) includes the program's goal of 80% coverage.

Indicator data came from the National Immunization Survey 2008, Centers for Disease Control and Prevention (CDC). This estimate is based on the provider-verified responses for children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. The numerator is the calculated number of children with completed immunizations. Denominator data came from the Washington State Office of Financial Management.

Notes - 2007
PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. A one percent increase every two years was chosen.

Numerator data came from the National Immunization Survey 2007, Centers for Disease Control and Prevention (CDC). This estimate is based on the provider-verified responses for children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. The numerator is the estimated number of children with completed immunizations. Denominator data came from the Washington State Office of Financial Management.

a. Last Year's Accomplishments
The state promoted the importance of fully immunizing children on time for the best protection. We gave health care providers tools, like the CHILD Profile Immunization Registry, to improve immunization services. We worked closely with providers, health insurers, local health, and partners to ensure children can get vaccine.

Childhood immunization rates increased some, showing progress toward targets. We continued the immunization activities that helped improve the rates.

One component to maintaining and increasing immunization rates was the use of an immunization registry.

Washington met its target of maintaining and increasing the number of health care providers participating in the registry. We did this through education and training of providers on the registry. The number of schools and Head Start/ECEAPs using the registry increased due to education and training.

Another component to maintaining and increasing immunization rates was quality assurance.

Washington contracted with local health agencies to do quality assurance immunization visits to provider sites enrolled in the childhood vaccine program. Local health had challenges completing site visits in 2009 because of H1N1 response work.

The goal of site visits was to assure accountability for vaccines purchased with federal and state funding and to improve standards and raise immunization coverage levels through use of provider assessment. The visits focus on provider education and training on current immunization practice and recommendations. This includes technical assistance for working with parents and use of the immunization registry. Provider coverage rate data was compiled and shared with providers to help raise rates. We also contracted with local health to work with providers on vaccine use and storage, and to assure community access to vaccination.

Washington assists school and child care providers on how to interpret immunization records, communicate with parents, and fill out immunization forms. We continued to work with the State Board of Health to update school and child care entry requirements, which allow for medical,

religious, and philosophical exemptions.

Exemption rates have increased. Anecdotal evidence suggests that many exemptions are for convenience reasons and do not represent true exemptions. There is more to do to lower the number of convenience exemptions. School use of the immunization registry gives parents easy access to accurate immunization records so they can complete the necessary paperwork.

Another component to maintaining and increasing immunization rates is through public education.

There are an increasing number of parents delaying or opting out of recommended immunizations. Our activities in this area include strong public education to parents and health care providers on the value of immunizations and the importance of child health.

Washington continued to send parents age-specific reminders of the need for well-child checkups and immunizations via the CHILD Profile Health Promotion system. We met our target measure, but continue to work toward our goal of reaching 90 percent of parents. We worked with partners to develop a social marketing initiative to address vaccine hesitancy and increase timely immunizations in young children. The first step was to develop a provider toolkit to facilitate conversations between parents and providers about immunizations. The toolkit will be piloted in 2010.

Washington also purchases and distributes recommended childhood vaccines to more than 1200 health care provider sites. The commitment to "universal childhood vaccine" ensures access to the vaccines children need to be protected. Some state funding was cut in July 2009 that stopped purchase of the HPV vaccine for children with private health insurance. We worked with private and public partners to develop a plan for sustained funding of the system.

Kids Matter informed early childhood providers about immunizations and promoted immunizing children 0--5 years.

Child Care Health Consultants (CCHCs) discussed immunization with infant and toddler child care providers. They gave tools and advice on how to keep and use immunization records, communicate with parents about immunizations, and fill out state-required immunization reports. Many consultants are nurses who access CHILD Profile for immunization recordkeeping. They spent time helping children access flu vaccine, which was used as an opportunity to remind parents about immunization.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Contract with LHJs and others to complete immunization AFIX visits to enrolled private provider sites.				X
2. Send parents age-specific reminders of the need for well-child checkups and immunizations via CHILD Profile Health Promotion.			X	
3. Maintain and increase the number of health care providers participating in the CHILD Profile Immunization Registry to improve access to historical records and use the system's immunization recommendation schedule.				X
4. Purchase and distribute recommended childhood vaccines for children under age 19 and work with partners to develop a strategy to maintain state funding to purchase vaccines.				X
5. Assist school personnel and providers of child care for infants		X		

and toddlers to organize and interpret immunization records, communicate with parents, and fill out state-required immunization reports.				
6. Work with public and private immunization partners to develop a social marketing strategy to address vaccine hesitancy in parents.		X		X
7.				
8.				
9.				
10.				

b. Current Activities
The Immunization Program CHILD Profile (IPCP) gives immunization registry access to schools to help reduce convenience exemptions. We work with the State Board of Health (SBOH) to update school and child care entry requirements. By April 2010, 81% of Head Start/ECEAPs enrolled in the registry. By April 2010, 54% of kids aged 19--35 months have complete records in the registry.

Quality assurance activities with contracted local health jurisdictions (LHJs) continue, with visits to at least 30% of VFC/AFIX enrolled sites. We train, assist, compile, and share provider coverage rate data with providers to help raise rates. We continue LHJ contracts to work with providers on vaccine use and storage and to assure community access to vaccination. We facilitate the order and receipt of vaccine.

We educate parents and providers on immunizations. We send age-specific reminders via the CHILD Profile Health Promotion system, currently reaching 87% of parents with children under 6; our goal is 90%. We are working with partners on a toolkit to help providers talk with vaccine-hesitant parents.

A new state vaccine financing law lets Washington retain the Universal Childhood Vaccine Program. We are working with partners on this change to support the purchase and distribution of all recommended vaccines for all children under 19.

CCHCs discuss immunization with infant and toddler child care providers. Many consultants are nurses who access CHILD Profile for recordkeeping.

c. Plan for the Coming Year
IPCP will continue to provide education and training to health care providers and schools on the immunization registry. This will help providers keep children's' immunizations up-to-date and help reduce the use of convenience exemptions to school and child care immunization requirements. We will continue to work with the SBOH to update school and child care entry requirements. We will continue to work with Head Start/ECEAPs to increase their use of the registry. We will continue to work with providers to increase the number of 19--35 month-olds that have complete records in the registry.

IPCP will continue its quality assurance activities with contracted LHJs to visits VFC/AFIX enrolled sites. We will continue to train and assist providers and compile and share provider coverage rate data to help raise rates. We will continue contracting with LHJs to work with providers on vaccine use and storage, and to assure community access to vaccination. We will continue to facilitate the order and receipt of vaccine.

We will continue to educate parents and health care providers about the importance of immunizations. This includes sending parents age-specific reminders of the need for well-child checkups and immunizations via the CHILD Profile Health Promotion system. We will also work

with partners to continue social marketing work to address vaccine hesitancy. Next steps include reviewing information gathered from piloting the provider toolkit to address vaccine hesitancy, revising the toolkit as necessary, and developing a statewide implementation plan for making the toolkit available to all health care providers in Washington. We will start to plan a community norms campaign as part of the overall social marketing work. It will look at strategies to enforce that fully immunizing your child is the community norm and support parents in being sure their child is immunized on time.

We will continue to purchase and distribute all recommended childhood vaccines to health care providers throughout the state. We will continue to work with public and private partners to implement the new funding that supports the Universal Childhood Vaccine Program.

Child care health consulting will end on December 31, 2010. Until then, CCHCs will continue to discuss immunization with infant and toddler child care providers. They will give tools to parents and give advice on immunization records, how communicate with parents about immunizations, and how to fill out reports. Many consultants are nurses who also access CHILD Profile for immunization recordkeeping.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14	15.5	15.4	15.3	15.2
Annual Indicator	14.9	15.2	16.1	15.5	
Numerator	1966	2062	2217	2131	
Denominator	132042	135315	137767	137469	
Data Source				WA Center for Health Statistics	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15.1	15	14.9	14.8	14.7

Notes - 2009
Birth data from WA CHS for 2009 not yet available.

Notes - 2008
PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. In 2005, discussions took place regarding the flattening of the rate at 14.0. The 75th percentile of states was at 15%, which was close to where Washington was; 15.2% at that point. A target of 15.5 % was chosen for 2006 with a 0.1 annual decrease targeted every year afterward. In 2010 further discussions with program staff resulted in the maintenance of the targeted change previously decided on.

Notes - 2007
PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. In 2005, discussions took place regarding the flattening off of the rate at 14.0. The 75th percentile state was at 15%, which was close to where Washington was at with 15.2%. A target of 15.5 % was chosen for 2006 wtih a 0.1 annual decrease targeted every year afterward.

a. Last Year's Accomplishments
Washington has historically had a decreasing trend. However in 2007 there was a slight increase in the rate.

MICAH provided technical assistance, consultation and capacity around comprehensive sex education to the state Office of the Superintendent of Public Instruction (OSPI), individual schools and school districts, and the general public.

In accordance with a state law passed in 2008, and in partnership with OSPI we reviewed sexual health education curricula for medical and scientific accuracy. We also responded to public inquires about this issue.

MICAH provided partial funding for two school-based health centers to provide services to students, including reproductive health care and health education. We conducted a series of conference calls on adolescent health topics such as using youth voice, academic achievement and health, and results of the Healthy Youth Survey.

With Title V Abstinence Education funds, MICAH contracted with the University of Washington to conduct focus groups in three sites across the state with youth ages 12-15 and their caregivers and parents. The purpose of these focus groups was to examine and plan messages and materials that could be integrated into a media campaign focused on abstinence and designed to target youth 12-15 and their parents.

MICAH contracted with University of Washington to convert an existing abstinence based media literacy curriculum to a comprehensive based curriculum. This curriculum was implemented in six communities. We also developed and tested a refresher lesson for this curriculum.

Walla Walla County received Robert Wood Johnson grant funds to reduce teenage pregnancy. OMCH supplemented this work with MCH Block Grant funds. This quality improvement project works with adolescent women ages 15-18 to prevent pregnancy. OMCH staff also provided technical assistance and consultation to this project.

Some local health jurisdictions provided Nurse Family Partnership (NFP) programs with MCH Block Grant funding. NFP works to prevent subsequent pregnancies among young women. NFP services include family planning education and referral.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Sponsored statewide adolescent health conference call series for professionals working with youth.				X
2. Partnered with state and local agencies to provide technical assistance, consultation and build capacity around comprehensive sex education through the use of DOH/Office of the Superintendent of Public Instruction (OSPI) Guidelines.				X

3. Funded two school-based health centers to deliver health care and education, including reproductive health care, to students.	X			
4. Reviewed sexual health education curricula for medical and scientific accuracy as required by state legislation				X
5. Converted an abstinence based media literacy curriculum to a comprehensive based curriculum.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MICAH is providing funding to three existing school-based health centers. The funding for one of these school based health centers is for a specific time-limited project to increase the immunization rate of the school population. The other two school-based health centers are receiving more long term funding that substantially supports their operations.

MICAH is working with the University of Washington to refine the Take it Seriously, Sex, Abstinence and the Media (TISSAM) media literacy curriculum. We are working to design and build a website and a portable TISSAM curriculum package that will allow us to sustain the implementation of this curriculum with limited resources.

OMCH continues to work with OSPI to review sexual health education curricula for medical and scientific accuracy.

Nurse Family Partnership (NFP) programs continue to be provided by some LHJs and MCH Block Grant funding provides support to some of these programs. NFP works to prevent subsequent pregnancies among young women. NFP services include family planning education and referral.

Walla Walla County is continuing to work with adolescent women to prevent pregnancy.

c. Plan for the Coming Year
Reducing the rate of births for adolescents (15-17) fits within our program priority of "Sexually responsible and healthy adolescents and women." In 2009, there were an estimated 735,295 Washington youth ages 12-19. This age range represents about 11% of the state population.

The teen birth rate has decreased significantly since 1996; however, most of this decrease occurred between 1996 and 2000. There has been no statistical change in the rate since 2003.

The rate of unintended pregnancy is higher among adolescents living in more rural areas of the state. Twelve counties have adolescent birth rates that are significantly higher than the state rate. County adolescent birth rates may also be influenced by demographic differences such as race and economic status.

When compared to non-Hispanic White adolescents; Hispanic, Non-Hispanic Black, and Non-Hispanic American Indian adolescents have significantly higher birth rates and Non-Hispanic Asian/Pacific Islander adolescents a significantly lower birth rate.

Birth rates for adolescents of all races and Hispanic origin have decreased significantly since the early 1990s but the decline for Washington Hispanic and American Indian adolescents has been slower than other groups. Differences in economic status, access to health care, and education

may account for some of these racial and ethnic rate differences. Pregnancy and birth rates may also be influenced by cultural values about sexuality, relationships, birth control, and abortion.

Statewide survey data on the sexual behavior of Washington State adolescents has not been available since 1995. Washington State will begin collecting sexual behavior data in 2010 through the school-based Healthy Youth Survey which is administered in grades 8,10, and 12.

DOH is applying for a Tier 1, replication of evidence based programs, teen pregnancy prevention programs grant. We will use it to implement the Making Proud Choices curriculum with middle school age children in targeted high risk communities. This curriculum was chosen because we believe it will be successful in Hispanic and Native American communities as well as in the general population.

OMCH anticipates that Washington State will receive additional teen pregnancy prevention funds through the Administration for Children and Families. We plan to use these funds to support additional evidenced based teen pregnancy and sexually transmitted disease prevention; healthy relationships; and parent-child communication. We expect these funds to be targeted toward high risk and vulnerable youth, including youth in foster care, teen parents, and youth who are homeless.

In addition to this new activity, the activities described in the Current Activities section will be ongoing.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55.5	55.5	50	50	50
Annual Indicator	50.4	50.4	50.4	50.4	
Numerator	41460	41460	42971	42725	
Denominator	82261	82261	85260	84771	
Data Source				Washington State 2005 Smile Survey	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	50

Notes - 2009
Data collection from the 2010 WA Smile Survey is in progress. Analysis will be taking place over the summer of 2010. A new Annual Indicator will then be available.

Notes - 2008

PERFORMANCE OBJECTIVES: The Smile Survey is only conducted every 5 years, and therefore only two data points exist, preventing accurate trend analysis. The 75th percentile state was at 49.4%. The Healthy People 2010 goal of 50% was chosen as the future objective through 2014, since it is attainable and will be an improvement on the historical decrease of dental sealants.

The denominator is the number 8 year olds in WA and comes from the WA Office of Financial Management. The numerator is calculated from the rate and the denominator.

The Washington State Smile Survey is conducted by the Department of Health every five years. During the most recent survey in 2005, thirty-nine Head start or ECEAP sites and sixty-seven public elementary schools with a 2nd or 3rd grade were randomly selected across the state during the 2004-2005 school year. All preschool children enrolled and present on the day of the screening were included in the sample unless the parent returned a consent form specifically opting out of the sample. Elementary schools could choose to use either an active or passive consent process. Each child participating in the survey received an oral screening exam to determine the child's caries experience, treatment need and urgency, and dental sealants needs. The indicator of 50.4% is gathered from the 2005 SMILE Survey. Denominator data came from the Washington State Office of Financial Management. The numerator is derived from these data.

The Smile Survey will be conducted again this coming school year beginning in the Fall 2009 school term and finishing in the Spring 2010 term.

The Smile Survey was developed in Washington State has been adapted and implemented by several other states.

Notes - 2007
PERFORMANCE OBJECTIVES: The Smile Survey is only conducted every 5 years, and therefore only two data points exist, preventing accurate trend analysis. The 75th percentile state was at 49.4%. The Healthy People 2010 goal of 50% was chosen as the future objective through 2013, since it is attainable and will be an improvement on the historical decrease of dental sealants.

The Washington State Smile Survey is conducted by the Department of Health every five years. During the most recent survey in 2005, thirty-nine Head start or ECEAP sites and sixty-seven public elementary schools with a 2nd or 3rd grade were randomly selected across the state during the 2004-2005 school year. All preschool children enrolled and present on the day of the screening were included in the sample unless the parent returned a consent form specifically opting out of the sample. Elementary schools could choose to use either an active or passive consent process. Each child participating in the survey received an oral screening exam to determine the child's caries experience, treatment need and urgency, and dental sealants needs. The indicator of 50.4% is gathered from the 2005 SMILE Survey. Denominator data came from the Washington State Office of Financial Management. The numerator is derived from these data.

The Smile Survey will be conducted again this coming school year beginning in the Fall 2009 school term and finishing in the Spring 2010 term.

The Smile Survey was developed in Washington State has been adapted and implemented by several other states.

a. Last Year's Accomplishments
In 2000, 55.5% of third graders had at least one sealant on their molar teeth. In 2005 (most recent data available), the rate appeared to decrease to 50.4%. Data was collected in 2010 and will be available for next year.

The Oral Health Program provided funding to all 35 Local Health Jurisdictions (LHJs) for a range of activities. This included providing sealants either directly or through contracting or coordinating services with community dental providers is one of the optional activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fund all LHJs to provide sealant.			X	
2. Promote and coordinate sealant programs around the state.			X	
3. Develop evaluation plan for school sealant programs.				X
4. Collect statewide sealant data.				X
5. Work with state coalition to improve coordination in state for sealant programs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Through HRSA grant 09-109, the State Oral Health Program has created a competitive mini-grant opportunity that provides funding for 5 LHJs to ensure that local dental providers follow the State Sealant Guidelines. This experience will work as a pilot project.

New legislation in Washington allows dental hygienists not only to do sealants but also teeth cleaning in school children and provide sealant data to the Dental Hygiene Examining Committee. The Oral Health program is working with this Committee to analyze the sealant data and develop a report to be submitted to the Legislature.

The 2010 Smile Survey was conducted in the 2009-10 school year. The survey was planned in 53 elementary schools and 48 preschools. County oversamples in both elementary and preschools were conducted in 32 counties.

c. Plan for the Coming Year

The Oral Health Program will continue to seek for funds to work with the LHJs, the state coalition, and dental providers to identify new opportunities to expand the school sealant programs in the state. If HRSA grant 10-109 is awarded, more mini-grants will be available for 20 more LHJs to ensure providers' compliance to the State Sealant Guidelines.

Analysis of the 2010 Smile Survey will be conducted in the coming months.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Performance Objective	2.5	2.5	2.4	2.4	2
Annual Indicator	3.1	1.7	2.0	1.1	
Numerator	39	21	26	14	
Denominator	1259643	1270785	1281739	1295245	
Data Source				WA Injury and Violence Program	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1.5	1.5	1.5	1.5	1.5

Notes - 2009
Data for 2009 are not available.

Notes - 2008
PERFORMANCE OBJECTIVES: Although there have been some fluctuations, over the past 12 years, an overall decrease has been observed. Rates are prone to a great degree of variance due to small numerators. Many years of data were used to assess the trends, therefore future targets may not appear to align with the most recent indicators. After discussions with program and assessment staff we decided to revise the performance objective downward based on the data in the last four years. Given the persistent low rate it was decided to drop the target by .5 child per 100,000, to a goal of 1.5 per 100,000 through 2014.

The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is from the Office of Financial Management Population Forecast. The data were accessed through the Community Health Assessment Tool (CHAT).

Notes - 2007
PERFORMANCE OBJECTIVES: Although there have been some fluctuations, over the past 12 years, an overall decrease has been observed, possibly due to use of seat belts, child safety seats, and airbags. Rates are prone to a great degree of variance due to small numerators. Many years of data were used to assess the trends, therefore future targets may not appear to align with the most recent indicators. The 95% confidence interval of the rate in 2007 was (1.3, 3.0) which includes the performance objective (2.4), and we conclude the indicator and the objective are not statistically significantly different. After discussions with program and assessment staff we decided to revise the performance objective downward based on the data in the last four years. The objective of 2.3 per 100,000 had been chosen as a goal through 2013, however in all but one of the past four years that goal had been achieved and bettered, a new goal which reflects the present rate of 2.0 has been settled on for future objectives.

The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is from the Office of Financial Management Population Forecast.

a. Last Year's Accomplishments
Washington has had an overall decreasing trend and met its objective. However, with the small number of deaths rates fluctuate significantly

OMCH staff was assigned to serve as a liaison with the Emergency Medical Services, Trauma System, and Injury & Violence Prevention Program, in the Office of Community Health Systems (OCHS). OMCH program and assessment staff participated in the DOH Injury Prevention Workgroup to coordinate injury prevention work, including motor vehicle safety, across the agency, and with various stakeholder groups.

OMCH provided funding to OCHS to enhance their injury prevention work. Funds were used to support a portion of a position that provides technical assistance and coordination for local Safe Kids Coalitions. Washington State has 18 local Safe Kids Coalitions. The Coalitions concentrate on unintentional injury prevention for children birth--14. Each coalition chooses three or more injury risk areas to work on. All of them have chosen Child Passenger Safety. The coalitions cover more than 95% of all children in this age range. Safe Kids Coalitions work in communities to check car seats, distribute free and reduced cost car seats to needy families, establish permanent fitting stations, and educate and bring awareness of child passenger safety.

OMCH worked with the 18 local Child Death Review (CDR) teams. These teams make policy and practice recommendations, including strategies for reducing child deaths due to motor vehicle crashes. Transition to the multi-state database was completed. OMCH sponsored a CDR Conference attended by 40 CDR Coordinators and stakeholders. Legislation passed requiring DOH to assist CDR Coordinators with data collection and to provide them technical assistance.

The Healthy Youth Survey (HYS) is implemented every two years in Washington State for students in grades 6, 8, 10 and 12. HYS was implemented in October 2008 and the data became available in March 2009. HYS includes questions on drinking and driving, seatbelt use, and riding with a drinking driver. State, county and school data from the HYS and fact sheets from 2002-2008 are available online at: www.askhys.net. Several presentations were made by OMCH Assessment staff on working with and communicating data.

The MCH Data Report chapter on Unintentional Injury, which includes motor vehicle crash data, was updated.

CHILD Profile health promotion materials provide parents with age-specific information about growth, development, safety, nutrition, and other parenting issues through monthly newsletters. This includes information about child passenger safety. Information is refined as statewide data changes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Disseminated child passenger safety information to parents statewide through CHILD Profile.			X	
2. Reviewed unexpected deaths of children through local Child death Review (CDR) teams.				X
3. Conducted surveillance of motor vehicle crash deaths to children through CDR process and disseminated data.				X
4. Collaborated with DOH Office of Community Health Systems to promote statewide injury prevention activities.				X
5. Collaborated with DOH Office of Community Health Systems section to implement State Injury Prevention Plan.				X
6. Transitioned to multi-state database for CDR.				X
7.				
8.				
9.				

10.				

b. Current Activities
OMCH works with the 18 current local CDR teams. These teams make policy and practice recommendations to reduce the rate of child and youth deaths. These include strategies for reducing child deaths due to motor vehicle crashes. Local CDR teams add data to the multi-state database.

OMCH is implementing legislation passed in 2009 requiring DOH to assist CDR coordinators with data collection, provide technical assistance, and encourage communication among CDR teams. No state funds were allocated for this work. The legislation stipulated that these activities must be conducted using only federal and private funding.

OMCH staff is assigned to serve as a liaison with the Emergency Medical Services, Trauma System, and Injury & Violence Prevention Program, in the Office of Community Health Systems (OCHS). OMCH continues to fund a portion of an OCHS staff FTE. OMCH program and assessment staff participate in the DOH Injury Prevention Workgroup to coordinate injury prevention work, including motor vehicle safety, across the agency and with various stakeholder groups.

OMCH staff work with OCHS on injury prevention activities, including implementing the State Injury Prevention Plan.

CHILD Profile sends child passenger safety information to parents of children aged 0-6 years. Information is refined as statewide data changes.

c. Plan for the Coming Year
Between 1990 and 2009 there has been a significant downward trend in deaths to young children caused by motor vehicle crashes. Variation from year to year is due to the small numbers involved.

Washington State has 35 local health jurisdictions (LHJs), each covering a county or multi-county area. 18 LHJs have CDR teams. OMCH will continue working with local CDR teams and to look for opportunities to expand capacity for CDR statewide. The data gathered by local CDR teams will be available to local, state, and national decision makers. CFR team recommendations will influence policy and practice aimed at reducing the rate of child and youth deaths, including deaths due to motor vehicle crashes.

A 1997 Governor's initiative funded planning and implementation of a statewide child death review system. This system was created by DOH, Department of Social and Health Services (DSHS), LHJs, and stakeholders and managed at the state level by DOH and DSHS. From 1998 to 2003 Washington's legislature continued to fund this effort with most of the funding flowing to local health jurisdictions (LHJs) to support local CDR teams. This funding was eliminated in the 2003-2005 Washington State biennial budget and no other funding source has replaced it. Data collected since 2003 is neither comprehensive nor statewide.

OMCH will continue to address this national performance measure (NPM10) as it has since 2003. Collaboration with OCHS and support to local CDR teams has allowed us to continue to address NPM10 with reduced resources.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		52	53	53	58
Annual Indicator	55.5	58.8	57.3	58.0	
Numerator	45857	47323	50951	52357	
Denominator	82625	80482	88921	90270	
Data Source				National Immunization Survey	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	58.5	58.5	59	59	59.5

Notes - 2009
National Immunization Data are not yet avalible

Notes - 2008
This measure changed in 2006, from breastfeeding at hospital discharge to six months or more after delivery. The Indicator rate comes from the National Immuniztion Survey, and can be highly variable due to small sample size (2008 n=400). The 95% Confidence Interval for 2008 (51.4%, 64.6%) included the target goal of 53% set previously.

Owing to the increase in the percentage of women breastfeeing in recent years, it was decided to increase the annual performance objective by 0.5 every two years through 2014.

The indicator is from the 2008 National Immunization Survey and includes the birth cohort from 2006. The denominator is the number of livebirths to WA residents in 2008. The numerator is calculated from the indicator and the denominator.

Notes - 2007
This measure changed in 2006, from breastfeeding at hospital discharge to six months or more after delivery. Rates are based on the National Immunization Survey, and are highly variable due to small sample size. The 95% confidence interval for 2007 was (50.8, 63.8) which includes the performance objective. After discussions with program and assessment staff we decided to revise the performance objective upward based on the data from the last two years.

The source of this data is the 2007 National Immunization Survey (NIS) which is reported for children born in 2005. As of July 2009 these data were reported as provisional by CDC. The numerator is based on the proportion of women who reported breastfeeding at six months or longer. The denominator was obtained from the live birth file, for Washington residents.

a. Last Year's Accomplishments
OMCH recognizes breastfeeding as one of the most important public health interventions for preventing and reducing infant morbidity and chronic disease. Washington State breastfeeding initiation rates have been 90% which is far above the Healthy Peoples goal of 75%. Washington met its six month duration target

In 2008, OMCH decided to focus more on improving the percentage of infants breastfeeding at 6 months of age. OMCH reviewed the Washington State breastfeeding duration data to evaluate progress and determine which interventions to continue and which to change. In 2009, 44% of women served by the Women Infant and Children's (WIC) supplemental nutrition program continued breastfeeding their infants until 6 months of age (WIC data), the same rate as in 2008. Another data source, the National Immunization Survey (NIS), showed Washington State breastfeeding rates at 6 months of age increased from 57.3% to 58% which is above the 2010 Healthy Peoples goal of 50%.

While the WIC number represented approximately 44,000 women, all of whom are under 185% of federal poverty level, the NIS is a smaller sample that is representative of the entire state population of new mothers. National survey results have shown consistently lower breastfeeding rates at six months among WIC mothers compared to non-WIC mothers. Thus, there is additional indirect evidence that supports Washington overall meeting the Healthy People 2010 goals. The following work promoted breastfeeding duration rates by mothers in Washington State, especially women served by Medicaid:

First Steps Maternity Support Services (MSS) agencies screened pregnant and postpartum Medicaid clients for breastfeeding knowledge, intent, and needs. This screening identified client gaps in knowledge, education opportunities, need for home visit support, and linkage to needed resources to support breastfeed initiation and duration.

MICAH's registered dietician updated and distributed breastfeeding talking points to assist MSS/WIC registered dieticians in communicating with clients in a supportive way and encourage continued duration beyond 6 months.

MICAH notified MSS/WIC registered dieticians of four breastfeeding training opportunities around the state (including a MSS online breastfeeding training module to support provider knowledge and client resources). Over half of the MSS registered dieticians have taken the online training and passed the knowledge testing with an 80% or above.

OMCH recommended lactation support at all hospitals with delivery services as recommended in the Perinatal Level of Care Guidelines document.

Eighty-seven percent of Washington's parents of children aged birth-6 years received CHILD Profile health promotion education materials in the mail that included breastfeeding support and tips based on American Academy of Pediatrics recommendations.

OMCH-led a cross-agency breastfeeding workgroup focused on improving breastfeeding workplace support (returning to work is one of major reasons women stop breastfeeding). This group posted resources for new mothers and supervisors via the DOH intranet and drafted a breastfeeding DOH policy.

The WithinReach Family Health Hotline (FHH) provided information and referrals to 145 callers with breastfeeding questions. Callers are also given information on how to obtain and pay for breast pumps.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided breastfeeding support and education to low income women receiving Medicaid through Maternity Support Services (MSS).		X		
2. Provided breastfeeding training for MSS providers which		X		

included techniques for supporting duration.				
3. Recommend lactation support at all hospitals with delivery services through the Perinatal Level of Care Guidelines document.				X
4. Reviewed breastfeeding data from the Women, Infants, and Children (WIC) Client Information Management Systems (CIMS), and the National Immunization Survey.				X
5. Through a state level breastfeeding workgroup, improved workplace support for breastfeeding mothers by Drafting a workplace policy, developed building guidelines, and staff breastfeeding resources.			X	
6. WithinReach Family Health Hotline (FHH) provided breastfeeding information and referrals to women and their families.			X	
7. Washington parents of children aged birth-6 years received CHILD Profile health promotion education materials in the mail that included breastfeeding support and tips based on AAP recommendations.			X	
8.				
9.				
10.				

b. Current Activities

OMCH monitors the percent of women breastfeeding their six month old infants using WIC and National Immunization Survey data.

OMCH-led cross-agency breastfeeding workgroup is working with DOH Human Resources section to approve a workplace breastfeeding policy and develop a logic model on workplace breastfeeding.

CHILD Profile educations mailings to families with young children include Breastfeeding information and support.

MSS coordinates with the WIC program to ensure women receive consistent breastfeeding messages and coordinated services. For example, WIC provides in-depth breastfeeding assessment and MSS supports home visits. MSS and WIC also coordinate to support providers with local trainings (including the MSS breastfeeding web training).

MSS screens pregnant and postpartum women for breastfeeding intent and knowledge, and provides health messages and support.

OMCH recommends lactation support at hospitals with delivery services as recommended in the Perinatal Level of Care Guidelines.

The Washington State Breast Feeding Coalition, housed at WithinReach, promotes breastfeeding state-wide. Their primary focus will be improving workplace support in a specific sector, such as hospitals.

The WithinReach Family Health Hotline provides information and referrals to callers with breastfeeding questions.

The CSHCN Program adds a Breastfeeding Chapter to the Nutrition Interventions for Children with Special Health Care Needs.

c. Plan for the Coming Year
Increasing breastfeeding rates is incorporated into our program's strategic plan and supports improving the health of Washington mothers and infants by preventing and reducing maternal and infant morbidity. This work also supports our OMCH priorities "Adequate nutrition and physical activity," and "Healthy physical growth and cognitive development."

Local and national data indicate American Indians, African Americans, Medicaid participants, and mothers younger than 20 years of age are less likely to initiate or continue breastfeeding for more than two months. National data from CDC show similar patterns in these populations among other states.

Public health efforts to improve breastfeeding practices should be broad-based and include community members as well as health care providers. Intervention strategies recommended by the Centers for Disease Control and Prevention focus on maternity care practices, increased support for breastfeeding in the workplace, peer support programs, educating mothers to change behaviors and attitudes, professional support for new mothers, and media and social marketing programs to influence social norms.

For many women, the decision of whether to breastfeed is made during pregnancy. The early decision influences both whether the mother begins breastfeeding and how long she continues. Reports of successful interventions with low-income women indicate that coordination among WIC, prenatal care, and maternal-newborn care is essential. Other studies have provided evidence that baby-friendly hospital practices influence whether mothers begin and continue breastfeeding. Breastfeeding instruction in the hospital. Increases success, while providing mothers with formula decreases breastfeeding success. Successful interventions to increase breastfeeding also need to consider the woman's age, social position, and culture, all of which influence beginning and continuing breastfeeding.

In Washington we plan to continue our current activities to educate providers, coordinate MSS and WIC services, and educate and connect women to local resources. In addition, MSS is providing additional support services to Medicaid women who are African American, Native Indian, under the age of 17 and/or are dealing with breastfeeding complications.

OMCH also plans to explore ways to coordinate with medical providers and hospitals on breastfeeding issues in hopes of improving maternity care practices that impact breastfeeding duration.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	96.5	97	97.5
Annual Indicator	94.4	96.5	95.3	95.7	95.6
Numerator	76241	77792	80067	81303	79963
Denominator	80728	80607	84043	84913	83666
Data Source				WA EHDDI program	WA EHDDI program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	97	97	97.5	97.5	98

Notes - 2009
Data reported by the Washington State Early Hearing-loss Detection, Diagnosis, and Intervention (EHDDI) program.

A consideration of present efforts and future plans for the program were used to set future targets. The national goal is to reach 95%, but since Washington State has already attained that, and 100% is not a realistic goal, a goal of 97% was set through 2011 with a 0.5 increase every two years, starting in 2012, following that.

Data exclude births which occur in military hospitals, and those parents who refused a hearing screen (1%). Homebirths attended by midwives who do not chose to conduct a screen are also missing and therefore not included. Some births to out of state residents may be included if they are reported by hospitals in Washington State.

Notes - 2008
Data reported by the Washington State Early Hearing-loss Detection, Diagnosis, and Intervention (EHDDI) program.

A combination of trend analyses and comparisons to other states were used to create the future objectives. The national goal is to reach 95%, but since Washington State has already attained that, and 100% is not a realistic goal, a 0.5% increase per year was chosen.

Data exclude births which occur in military hospitals, and those parents who refused a hearing screen (1%). Homebirths attended by midwives who do not chose to conduct a screen are also missing and therefore not included. Some births to out of state residents may be included if they are reported by hospitals in Washington State.

Notes - 2007
Data reported by the EHDDI program.

A combination of trend analyses and comparisons to other states were used to create the future objectives. The national goal is to reach 95%, but since Washington State has already attained that, and 100% is not a realistic goal, a 0.5% increase per year was chosen.

Data exclude births which occur in military hospitals, and those parents who refused a hearing screen (1%). Homebirths attended by midwives who do not chose to conduct a screen are also missing and therefore not included. Some births to out of state residents may be included if they are reported by hospitals in Washington State.

a. Last Year's Accomplishments
For the last three years The Early Hearing-loss Detection, Diagnosis, and Intervention program (EHDDI) has been screening 95% or more of all children born in the state. All non-military hospitals currently participate in the program, and EHDDI has been turning its attention to screening home births. (We've already been contracting with a midwife to screen home births, and are looking to expand those efforts.)

The EHDDI program selected Neometrics, a company specializing in data management solutions

for newborn care, to customize its off-the-shelf hearing tracking and surveillance system to meet program needs. The new system will replace the current tracking and surveillance system, which has several problems and is no longer supported by IT staff. The new system will track infant hearing screening, diagnosis, and referral to early intervention. It will also link with the Newborn Screening Program (dried blood spot).

We worked with Neometrics to develop the new system and hosted a hands-on training for pediatric audiologists so they could learn about the web application that they will use to report diagnostic results. The audiologists looked at an early version of the system and offered extensive feedback on its appearance and functionality. During the meeting, the audiologists and the EHDDI program also came to a consensus on the data items the audiologists will report.

We contracted with Seattle Children's Hospital (SC) to provide training and technical assistance to hospital hearing screeners and audiologists. We also contracted with Washington Sensory Disabilities Services to provide training and coaching to early intervention providers. A new contract was initiated with a midwife to provide newborn hearing screenings for infants born out of hospital in Thurston, King and Snohomish Counties. Because of this project, the number of out-of-hospital births screened increased in each of the three counties and already one infant with profound hearing loss was identified.

EHDDI staff also posted materials about screening, diagnosis, and early intervention resources on the Health Education Resource Exchange (HERE) website (www.here.doh.wa.gov). We also added information about the importance of hearing screening to the CHILD Profile (Children's Health, Immunization, Linkages and Development) newsletter sent to all new mothers whose infants are approximately one month of age. CHILD Profile distributes this letter in English and Spanish to new parents and guardians, including biologic, foster, and adoptive parents.

To monitor whether infants with hearing loss enter early intervention services by six months of age, the EHDDI program entered into a data sharing agreement with the Infant Toddler Early Intervention Program (ITEIP our state's Part C program). We paid for programming within their surveillance system to generate quarterly data reports that will allow us to track early intervention enrollment for infants diagnosed with hearing loss.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop and maintain an early hearing-loss detection, diagnosis, and intervention (EHDDI) tracking and surveillance system.				X
2. Contract with Seattle Children’s to promote universal newborn hearing screening in birthing hospitals.			X	
3. Contract with Washington Sensory Disabilities Services to provide early intervention training to county representatives.			X	
4. Contract with a midwife to provide newborn hearing screening opportunities at three home birthing and/or play centers in King and Pierce Counties.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
EHDDI and Neometrics continued to develop and test the new surveillance system which is going live in July, 2010. In September 2010, EHDDI and SCH will host a training for audiologists to review pediatric audiology diagnostic best practices guidelines in detail and discuss why each component of the protocol is essential. We will also unveil the new web application audiologists will use to report diagnostic results to EHDDI.

We contract with Seattle Children's Hospital (SCH) for training and technical assistance for hospital hearing screeners and audiologists and contract with a midwife to screen infants born out-of-hospital in Thurston, King, and Snohomish Counties.

To reach more young mothers and mothers with low levels of education in our target populations, we sent about 250 posters on hearing loss to Women, Infants, and Children (WIC) clinics. We encouraged WIC providers to ask clients if they knew their infants' hearing screening results. The "What does your baby hear?" poster uses pictures to describe types of hearing loss and reminds mothers to check their babies' screening results.

In response to a Request for Application (RFA) issued in January 2010, we are awarding funds to two birthing hospitals to improve newborn hearing screening and follow-up care coordination. The RFA aims to: a) decrease loss-to-follow-up by 20% in the contractors' communities and b) create collaborations between health care providers, parents, and other community resources.

c. Plan for the Coming Year
We will further systematize data integration with the Infant Toddler Early Intervention Program (ITEIP). Rather than receiving quarterly reports, we hope to establish a real-time data summary and referral process between the ITEIP and EHDDI databases. This way EHDDI staff could provide the parents' FRC contact information at the time of diagnosis as opposed to waiting for audiologists to refer babies to a lead County Family Resource Coordinator .

The EHDDI program will support the county projects awarded through a Request for Application (RFA) process to two birthing hospitals. The hospitals plan to purchase new equipment, update screening protocols, re-train screening staff, and consult with parent guides from the Washington State Hands and Voices Guide by Your SideTM (GBYS) program.

We will contract with the GBYSTM program to support parents of infants who did not pass hearing screens, or who are diagnosed with hearing loss. Trained parent guides will provide unbiased information about hearing loss, services, communication approaches, and early intervention programs, as well as help parents navigate these services.

We plan to collaborate again with Washington Sensory Disabilities Services to provide further trainings using the Ski-Hi curriculum developed specifically for working with infants with hearing loss and their families. To date, early intervention providers in all but seven counties in Washington have received training and coaching.

Lastly, we will continue contracts with Seattle Children's Hospital, to provide training and technical assistance to hospital hearing screeners and audiologists, and with the midwife who screens infants born out-of-hospital in three counties. We hope to expand the latter project by contracting with other midwives in Central and Eastern Washington.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	5	4	4	4
Annual Indicator	6.0	4.4	4.4	4.6	4.6
Numerator	97158	72158	72979	76954	77211
Denominator	1619803	1639962	1658605	1672915	1678507
Data Source				2008 Washington State Population Survey	2008 Washington State Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	3	3	3	3

Notes - 2009
The source of the Indicator rate is the 2008 Washington State Population Survey, from the Washington State Office of Financial Management. The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 18. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

Recent reform in Federal Health Care policy will impact rates of coverage. Performance objectives are being left "as is" until the impact of the Federal reform at the state level becomes clearer.

Notes - 2008
PERFORMANCE OBJECTIVES: Decreasing targets were chosen due to the new law going into effect July 2007, granting children health insurance. Phase 2 of this law goes into effect in late 2009.

The data source is the 2008 Washington State Population Survey, from the Washington State Office of Financial Management. The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 18. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

Notes - 2007
No new data avaliable for percent of uninsured kids. Rate same as reported last year.

a. Last Year's Accomplishments

In 2009 all but 4.6% of Washington children had health insurance. While this does not meet our target, it is low. Assuring all children in our state have health insurance, has been one of our governor's priorities since she took office in 2005. In 2009, state subsidized insurance for children was increased to 300% federal poverty level. This expansion has received federal approval that allows Washington State to receive SCHIP matching funds.

In Washington, the Department of Social and Health Services (DSHS) administers state children's health insurance programs. DSHS was also funded to conduct outreach for expanded children's health insurance starting in 2007. DSHS provides updates related to insurance options for children with OMCH.

The following DOH activities supported children's access to health insurance and health services:

OMCH worked with stakeholders to implement the plan to improve use of early periodic screening, diagnosis, and treatment (EPSDT), including pilot projects, quality improvement, health literacy, and incentives for quality screening.

DOH participated on an interagency group to enhance health literacy and identify performance indicators for quality health care.

WithinReach's Family Health Hotline (FHH) and Apple Health for Kids Hotline referred families with children to benefit programs, including Medicaid and SCHIP, and provided information about children's health and services for children. During this period 11,335 callers with children called the FHH and 9,518 called the Apple Health for Kids Hotline. Over 11,000 Families used WithinReach's ParentHelp123.org to screen themselves for benefits programs and apply online. ParentHelp123.org also provides information on health and healthy choices including: pregnancy, substance abuse and tobacco cessation, nutrition, physical activity, healthy relationships, breastfeeding, postpartum and interconception health, child development, parenting, immunizations, and oral health.

CHILD Profile distributed the Apple Health for Kids insert in health promotion mailings to parents of young children. It refers parents to the Apple Health for Kids Hotline and the ParentHelp123.org website.

Maternal, Infant, Child, and Adolescent Health (MICAH) funded two school-based health centers (SBHC) that coordinated with medical homes for students enrolled in the SBHC.

OMCH participated on interagency committees to expand health insurance coverage for all children. OMCH partnered with DSHS to implement the outreach and education component of the children's health insurance legislation.

Children with Special Health Care Needs (CSHCN) shared materials from the national Catalyst Center on the issues of the uninsured and underinsured children with special health care needs with partners and stakeholders.

CSHCN funded the University of Washington Adolescent Health Transition project to increase access to health care for youth with special needs transitioning into adulthood. CSHCN is also working on epilepsy, and autism projects; one aspect of these projects is increasing access to health care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinated with other key organizations and agencies to				X

ensure that children, teens, and their families have access to health care services.				
2. WithinReach operated the Family Health Hotline, Apple Health for Kids Hotline, and ParentHelp123.org, linking families to children's health insurance and other programs.			X	
3. CHILD Profile distributed Apple Health for Kids insert in mailings.				X
4. OMCH funded two school-based health centers.	X			
5. Adolescent Health Transition, Epilepsy, and Autism Projects increased access to health care for youths with special needs.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All activities in the Last Year's Accomplishments continue.

MICAH funds two SBHCs that coordinate with medical homes for students enrolled in the SBHC. We fund another SBHC for a short term immunization project and for coordinating with enrollees medical homes. Budget reductions have put on hold MICAH's effort to expand the number of SBHCs it funds.

WithinReach's hotlines continue to refer families with children to benefit programs and provide information about family and children's health and services for children. Families use ParentHelp123.org to screen themselves and apply for benefits programs and to access health related information.

CHILD Profile continues distributing age-specific health materials to Washington families of children birth to age six. Apple Health for Kids information is included in these mailings.

CSHCN continues to fund the Adolescent Health Transition project and implement the epilepsy, and autism projects; one aspect of these projects is increasing access to health care. CSHCN continues to receive updates from DSHS about insurance options for children and youth with special health care needs.

OMCH coordinates with and disseminates information to partners, especially family organizations, to help them access the most current and useful information about coverage options for their children. This includes information on the Office of Insurance Commissioner's new Statewide Health Insurance Benefits Advisors HelpLine.

c. Plan for the Coming Year
Reducing the percent of children without health insurance fits within our program priority of "Access to preventive and treatment services for the MCH population."

State subsided insurance now covers children up to 300% FPL and includes population groups not covered by federal Medicaid. These coverage levels have been maintained, despite state budget reductions that have resulted in cuts to many programs. Outreach for children's health insurance, including the Apple Health for Kids Hotline, is being cut.

DOH will continue activities to promote access to health insurance and health services for children, including contracting for the toll-free Family Health Hotline, disseminating information to

partners and families, and working on projects focusing on children with special health care needs.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		29	29	29	29
Annual Indicator	29.2	28.9	29.4	30.4	30.3
Numerator	24679	25518	26081	29029	32120
Denominator	84520	88312	88709	95359	106173
Data Source				WA State Women Infants and Children Program	WA State Women Infants and Children Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	30	30	30	30	30

Notes - 2009
The source of these data are the Washington State Department of Health, Women, Infants, and Children (WIC) program. The numerator is the number of overweight (BMI > 85th percentile) children, ages 2 to 5 years, who receive WIC services during CY 2009. The denominator is number of children, ages 2 to 5 years, who receive WIC services during the reporting year

Notes - 2008
PERFORMANCE OBJECTIVES: Trend analyses and discussions with WIC staff resulted in future targets of 29% through the year 2013. Maintaining current rates would be an improvement, showing that the rate of children becoming overweight is not increasing

The source of these data are the Washington State Department of Health, Women, Infants, and Children (WIC) program. The numerator is the number of overweight (BMI > 85th percentile) children, ages 2 to 5 years, who receive WIC services during CY 2007. The denominator is number of children, ages 2 to 5 years, who receive WIC services during the reporting year.

Notes - 2007
PERFORMANCE OBJECTIVES: Trend analyses and discussions with WIC staff resulted in future targets of 29% through the year 2012. Maintaining current rates would be an improvement, showing that the rate of children becoming overweight is not increasing.

The source of this data is the Washington State Department of Health, Women, Infants, and Children (WIC) program. The numerator is the number of overweight (BMI > 85th percentile)

children, ages 2 to 5 years, who receive WIC services during CY 2007. The denominator is number of children, ages 2 to 5 years, who receive WIC services during the reporting year.

a. Last Year's Accomplishments
The prevalence of childhood obesity in Washington has increased over the past decade or more, and has been relatively stable for the last four years. Multiple programs and interventions in OMCH have contributed to this stabilization.

CHILD Profile has included brochures on nutrition for infants, toddlers, and older children, and tips on eating at school and away from home and physical activity for older children. CHILD Profile materials are age-specific and mailed every three to six months to Washington families with children from birth to age six. CHILD Profile regularly evaluates its materials for usefulness, accuracy, and timeliness.

Bright Futures has been the standard of well-child care and parent guidance endorsed by OMCH. Staff members were introduced to the third edition of the guidelines and encouraged to disseminate this information to stakeholders.

The third edition of the Bright Futures Guidelines, is part of the training MICAH staff provide to child care health consultants (CCHCs) in the Healthy Child Care Washington program. It emphasizes new themes: Healthy Weight, Healthy Nutrition, and Physical Activity. CCHCs also use Caring for Our Children, from the American Academy of Pediatrics, as a best practice in child care health. Caring for Our Children includes information on nutrition and physical activity.

OMCH maintained a Bright Futures web page, which contains links to other websites and resources that support children and families. These include information about nutrition and physical activity.

Early Childhood Comprehensive Systems (ECCS) grant activities encouraged early childhood providers and systems to include nutrition and physical activity strategies in their work.

MICAH funded two school-based health centers (SBHC) that provided students with information on the importance of healthy food choices and physical activity.

First Steps Maternity Support Services (MSS) provided eligible women with information on nutrition and physical activity. MSS providers include registered dieticians. The Family Health Hotline and ParentHelp123.org, both run by WithinReach and partially funded by OMCH, also provide information on these topics to Washington parents and families.

OMCH collaborated with other DOH programs such as Coordinated School Health, the Nutrition and Physical Activity Program (NPA), and Environmental Health, to promote nutrition and physical activity changes in schools and homes.

OMCH coordinated with NPA to encourage implementation of the Washington State Nutrition and Physical Activity Plan. This plan calls for action at all levels including schools, health care, and transportation to make physical activity a part of everyday life. NPA also managed the Healthy Communities Washington, an initiative that supports increased physical activity and healthy choices. About one third of Washington's counties participated in this project.

MCH Assessment updated the MCH Data Report Chapter on Child Weight and Physical Activity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Disseminated nutrition and physical activity information to parents statewide through CHILD Profile.			X	
2. Coordinated with internal and external partners to promote nutrition and physical activity.				X
3. Provided training and consultation regarding nutrition and physical activity to child care providers through child care health consultants.				X
4. Promoted use of Bright Futures guidelines including Physical Activity and Nutrition.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
OMCH is continuing all of the activities discussed in the Past Accomplishments section. We continue to look for opportunities to collaborate within DOH and with external partners and stakeholders to maintain or enhance existing programs within a reduced budget.

MICAH sponsored an April 2010, conference for CCHCs that included information on improving health and nutrition in child care settings as well as in the home. Thirty-seven consultants from 27 local health jurisdictions participated. Topics covered included infant development and feeding guidelines; the latest food pyramid; meal and snack patterns; and the children's activity pyramid, which promotes activities such as outdoor play, active aerobics, and flexibility and strength for children.

ECCS is assisting in creating a new state Early Learning Plan. One of the outcomes of this plan, in the Ready and Successful Children portion: "All children have optimal physical health...and nutrition." The plan will include strategies emphasizing nutrition to support this outcome.

The CSHCN Program adds new Chapters on Breastfeeding and Physical Activity to the Nutrition Interventions for Children with Special Health Care Needs, 3rd edition, 2010. Working with the State WIC Program, The hard copies of this publication is available to all WIC dietitians.

c. Plan for the Coming Year
Washington will continue working to stabilize this rate. There has been a slight upward trend in WIC recipients ages 2-5 with a BMI at or above the 85th percentile since 2004. OMCH, WIC and the DOH Office of Nutrition and Physical Activity continue to work toward a rate of 29% or less.

CHILD Profile will continue provide parents and providers access to educational material related to nutrition and physical activity and to evaluate these materials regularly. MICAH will continue to collaborate with early childhood partners to continue their strategy of supporting messages related to nutrition and physical activity. MICAH will also continue activities with prenatal, postpartum, infant, family, and youth partners to share information and encourage healthy behaviors, including nutrition and physical activity.

OMCH will continue to raise awareness of the importance of maintaining healthy weight and the impact this has on the health of children, families and communities. OMCH will also continue to provide information about Bright Futures to other DOH offices and to partners within the limits of our funding. OMCH will maintain the current DOH Bright Futures webpage. This webpage provides information about Bright Futures and links to Bright Futures resources and materials. It

encourages health professionals, public agencies, parents, and other adults who work with children and youth to use Bright Futures.

OMCH will continue to implement strategies outlined in the Washington State Nutrition and Physical Activity Plan. The plan allows opportunities for development of policies and modification of environments in a manner that encourages healthy lifestyles. For example, the plan encourages physical activity, healthy choices in food selections, increasing access to health-promoting foods, reduction in food insecurity, increasing active community environments, and increasing access to physical activity opportunities for children.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		10	9.1	9.1	9
Annual Indicator	9.2	9.2	9.4	11.2	
Numerator	7602	7990	8359	10110	
Denominator	82625	86845	88921	90270	
Data Source				Pregnancy Risk Assessment Monitoring System (PRAMS	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9	8.9	8.9	8.8	8.8

Notes - 2009
PRAMS data for 2009 are not yet available.

Notes - 2008
Washington State is in the forefront fo states in this measure. Recent budget cuts in tobacco prevention may be counterbalanced by increased taxes on cigarettes, so anticipating change and its direction, at this point is difficult. Decision made to leave previous targets in place.

The indicator is the percent of women who reported smoking in the third trimester of pregnancy in the Pregnancy Risk Assessment Monitoring System (PRAMS) in 2008. The denominator is the number of WA resident births in 2008. The numerator is calculated from the denominator and the indicator.

Notes - 2007
PERFORMANCE OBJECTIVES: Washington State is in the forefront of states in this measure. Looking at trending in the data, a 0.1% decrease every other year was chosen.

This indicator is based on the proportion of women reporting smoking in the last three months of pregnancy and is from the Pregnancy Risk Assessment Monitoring System (PRAMS), 2008. The denominator are the number of women delivering babies during the year and are from the Washington State Department of Health Center for Health Statistics. The numerator is derived from these data.

a. Last Year's Accomplishments

Pregnancy Risk Assessment Monitoring System (PRAMS) data measured smoking rates before, during, and after pregnancy, quit rates, relapse rates, third trimester smoking trends, and disparities among groups. 2008 PRAMS data showed that 20.2% of women smoked 3 months before pregnancy; 32.2% of women quit smoking when they found out they were pregnant; 11.2% smoked during the last 3 months of pregnancy; and 42.5% relapsed after pregnancy.

The percentage of women who smoked during the last 3 months of pregnancy is higher than the rates for 2005-2007, but this increase is not statistically significant. Overall, the annual percent change has averaged a 2% decrease.

Low income pregnant women smoke at significantly higher rates than non-Medicaid pregnant women. According to 2008 PRAMS, 5.5% of non-Medicaid women smoked during the last 3 months of pregnancy, compared to 17.4% of Medicaid women.

Maternal, Infant, Child, and Adolescent Health (MICAH) staff attended meetings of the statewide Perinatal Advisory Committee and conferences for medical providers and disseminated information about the Medicaid smoking cessation benefit and the Washington State QuitLine. MICAH encouraged providers to perform a smoking intervention with pregnant women and women of child-bearing age.

MICAH and First Steps staff worked with professionals to revise the Smoking Cessation During Pregnancy best practice booklet to improve the quality of smoking cessation interventions by medical professionals. This booklet was published via internet.

MICAH and its partners provided training to 33 First Steps providers and technical assistance to 150 First Steps providers regarding compliance with First Steps' Tobacco Cessation During Pregnancy performance measure. This measure requires that tobacco cessation interventions, relapse prevention, and interventions to eliminate second hand smoke exposure be conducted and documented by First Steps providers. Interventions focused on tobacco cessation or reduction during pregnancy, and reducing or eliminating prenatal and pediatric exposure to second hand smoke. They included client centered education and referrals to the Quit Line. 15,853 First Steps clients received these interventions. Billings were monitored for agency compliance in offering these interventions to all Medicaid clients.

MICAH and its partners informed 56 First Steps provider agencies and medical providers about the Quit Line's fax referral system. This system allows providers, with patient approval, to fax contact information to the Quit Line on behalf of the patient. Quit Line staff make three attempts to contact the patient and initiate services. The provider receives a brief report of the results. The Quit Line offers free pregnancy-specific tobacco cessation services to all pregnant and parenting women.

OMCH and MICAH assisted the Tobacco Program in the last phase of a CDC funded Quit Line enhancement project. During this phase an evaluation of the previous phases was conducted. This evaluation guided the implementation of a pilot project designed to:

1-Train First Steps Maternity Support Services staff to complete the fax referral process and to offer a $10 gift card as an incentive to encourage pregnant women who smoked to participate in the fax referral process.

2-Measure the increase in the number of women willing to participate in the Quit Line fax referral process. This included signing the referral form and receiving a call from the Quit Line.

Fifty one First Steps agency sites agreed to pilot the project. Participating agencies received a package with customized First Steps fax referral forms and ten $10 gift cards. The gift cards were valid only at businesses that did not sell tobacco or alcohol products. Additional gift cards were available to First Steps Agencies when needed.

WithinReach Family Health Hotline (FHH) operators asked callers if anyone in the home smoked and offered referrals to the Quit Line. 782 callers to FHH said that they or someone in their house smoked. Of these, 447said they were pregnant and 501 said there was a child in the home. There is some duplication in these counts as a caller could be both pregnant and have a child in the home. 104 callers were referred to the Quit Line. WithinReach also has information about how to get smoking cessation help on its website, parenthelp123. Due to budgetary constraints, WithinReach no longer mails health education packets to callers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promoted the Medicaid Smoking Cessation benefit to providers.				X
2. Collected and referred to Pregnancy Risk Assessment Monitoring System (PRAMS) data to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups.				X
3. Informed and educated professionals about the FAX Back Referral program and other QUIT Line services.				X
4. Revised best practice guide for smoking cessation for medical providers.				X
5. Shared tobacco data with First Steps providers and perinatal providers.				X
6. Through WithinReach, referred callers with tobacco in their home to the Quit Line as appropriate.			X	
7. Worked with the Tobacco Program to implement their CDC funded Quit Line enhancement project that focuses on pregnant women and relapse prevention			X	
8.				
9.				
10.				

b. Current Activities

State budget cuts to the tobacco program are scheduled to be implemented this budget year. DOH completed the CDC Quit Line Enhancement project, ending that source of funds.

MICAH continues to use PRAMS to track smoking rates, inform providers of the Medicaid Medical Program smoking cessation benefit, and disseminate information on the best practice guide for smoking cessation to medical providers.

FHH continues to ask callers if there is a smoker in the home and offer Quit Line referrals as appropriate. WithinReach began mailing a postcard of useful phone numbers and websites, including the Quit Line's, to callers.

The Quit Line and fax referral system are still in place, but MICAH and its partners no longer

provide training about them. MICAH and First Steps providers continue to inform medical providers about the fax referral system to increase its use and the use of other Quit Line services for pregnant women. We expect the lack of trainings will result in less Quit Line fax referrals which will negatively impact some of the close to 15,000 pregnant and parenting women who use or are exposed to tobacco.

We discontinued training First Steps providers on tobacco cessation during pregnancy. These trainings increased compliance with performance measure requirements and supported client centered interventions. All of these cuts lead us to expect that fewer women will receive smoking cessation interventions

c. Plan for the Coming Year

Reducing smoking during pregnancy is incorporated in the MICAH strategic plan and supports the goal of improving the health of Washingtonians, including the health of women, infants, and their families. It also fits within the OMCH priorities of "Lifestyles free of substance use and addiction" and "Access to preventive and treatment services for the maternal and child population."

Tobacco cessation services for pregnant women and tobacco cessation training for First Step providers are being scaled back because the state does not have the funds to continue supporting them. Tobacco cessation services are no longer covered as part of First Steps. We have not been able to implement an on-line training module for First Steps providers, meaning that with the high provider turnover, there will be many providers who have not been trained in tobacco cessation. Furthermore, in the new First Steps risk assessment system, tobacco use alone does not qualify a pregnant woman for the maximum level of maternity support services.

The declining economy and extra state taxes placed on tobacco products starting May 1, 2010 may inhibit some smoking.

These budget cuts and program changes will limit the quality and amount of smoking cessation services available to low income pregnant women. This will likely increase the disparity in smoking rates between Medicaid and non-Medicaid pregnant women. African American and Native American pregnant women have especially high smoking rates and these may also get worse unless cut services are restored or replaced.

We will continue to track percentages of pregnant women who smoke to see if the long term trend of decreasing smoking rates in the last three months of pregnancy continues or if the small increase we saw in 2008 marked the beginning of a new trend. We will look for opportunities to address smoking during pregnancy, particularly among low income and high risk women.

We will continue to disseminate best practice information to First Steps providers. WithinReach will continue to refer people to the Quit Line via their hotlines and parenthelp123 website.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	8.9	8.9	8.8	8.7	7.9
Annual Indicator	9.1	8.5	8.0	7.6	

Numerator	41	39	40	36	
Denominator	450402	459182	497786	472122	
Data Source				WA Center for Health Statistics	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7.8	7.7	7.6	7.5	7.4

Notes - 2009
Data not yet available.

Notes - 2008
The numerator for this rate is defined as the number deaths with ICD 10 Codes X60-X84 and Y87.0 and U03 for youth ages 15-19. The denominator is the estimated population for ages 15-19. The rate is per 100,000 population. The source for the data is the Washington Center for Health Statistics Death Certificate files (updated annually between September and October). Data were accessed via the Community Health Assessment Tool (CHAT).

The 2008 95% confidence interval (7.6, 10.6) includes the performance objective.

Notes - 2007
PERFORMANCE OBJECTIVES: Trend analyses and interdepartmental discussions took place to choose future objectives. Rates are subject to considerable variance and trends are based on many years of data, so future targets may not appear to align with the most recent results. The 2007 95% confidence interval (5.7, 10.9) includes the performance objective. After discussions with program and assessment staff we decided to revise the performance objective downward based on the data from the last four years. Because of the small numbers, the rates are highly variable. A conservative annual decrease of 0.1 in the rate/year was chosen.

The numerator for this rate is defined as the number deaths with ICD 10 Codes X60-X84 and Y87.0 and U03 for youth ages 15-19. The denominator is the estimated population for ages 15-19. The rate is per 100,000 population. The source for the data is the Washington Center for Health Statistics Death Certificate files (updated annually between September and October) and the Office of Financial Management, Intercensal and Postcensal Estimates of County Population by Age and Sex.

a. Last Year's Accomplishments
The suicide rate has been declining. We met our 2008 target, our most recent year of data.

OMCH worked with the Emergency Medical Services, Trauma System and Injury and Violence Prevention Program, in the Office of Community Health Systems (OCHS) on youth suicide prevention. Other areas both offices work on are family violence prevention, injury prevention, promoting mental health and adolescent health. MCH and OCHS partners helped market the youth suicide prevention plan and implement strategies.

OMCH program and assessment staff participated on the DOH Family Violence Prevention Workgroup to share information, coordinate activities, and raise awareness of family violence prevention, including suicide prevention.

OCHS led implementation of statewide youth suicide prevention activities. OMCH promoted programmatic activities, provided links to related activities, and shared critical data sources. OMCH provided data and input for the revision of the State Youth Suicide Prevention Plan (revised 2009, see below).

OCHS implemented local and statewide programs using a grant from the Substance Abuse Mental Health Services Administration (SAMHSA) for youth suicide prevention. Funds augmented state funded efforts and supported work in more targeted communities, including two Tribes, three college campuses, and within a homeless/street youth program. OCHS finalized the Washington State's Plan for Youth Suicide Prevention 2009 with input from OMCH and other stakeholders. Over 1,000 people received a copy of this plan and many more accessed it through the DOH website. Specific outreach to OMCH programs such as CSHCN and Adolescent Health took place.

OCHS developed and enhanced the DOH website with information about youth suicide prevention. www.doh.wa.gov/preventsuicide

Program planning included incorporation of recommendations from the evaluation of the Youth Suicide Prevention Program (YSPP). Results showed that youth who were aware of suicide prevention messages in schools were more likely to seek help for a friend than those who were unaware of these messages. The YSPP provides schools with a way to share these messages with youth. YSPP also organized community coalitions in eight counties with higher rates of youth suicide, with the goal of building initiatives to help prevent youth suicide at a local level.

The 2008 Healthy Youth Survey included data on depression, suicidal thoughts, suicide plans, and suicide attempts. There were questions about help-seeking behavior and whether or not there was an adult that youth felt they could turn to if they needed help (these are outcomes from curricula implemented in schools across Washington). HYS is implemented every two years in Washington State for students in grades 6, 8, 10 and 12. State, county and school data from the HYS and fact sheets from 2002-2008 are available online at: www.askhys.net. OMCH Assessment staff made presentations to schools, counties, and other stakeholders on working with and communicating data.

The MCH Data Report chapter on Intentional Injury (including suicide data) was updated.

OMCH worked with OCHS and other stakeholders to continue dissemination of the Washington State Injury & Violence Prevention Guide which includes a focus on suicide prevention. Strategies and objectives of the Guide were cross-referenced and incorporated into the youth suicide prevention plan.

OMCH conducted surveillance of suicide deaths through the local Child Death Review (CDR) teams. These teams make policy and practice recommendations to reduce the rate of child and youth deaths, including strategies for preventing suicide. OMCH administered Washington's participation in a multi-state CDR database and worked with the National Center for CDR to add the data from the old Washington State database into the multi-state database. OMCH provided technical assistance to CDR teams regarding use of the database, best practices, and effective team practices.

OMCH promoted the use of the Harborview Injury Prevention Research Center web-based decision-making tool. The tool was refined to assist CDR teams in reviewing promising practices, strategies, and evidence-based interventions. The website includes interventions specific to preventing youth suicide. http://depts.washington.edu/cdreview. The information gathered by Harborview was expanded by Michigan Public Health Institute's National Center for Child Death Review and is not available online at:

http://childinjuryprevention.org.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with DOH Office of Community Health Systems to support youth suicide prevention.				X
2. Conducted surveillance of suicide deaths through Child Death Review (CDR) and disseminated data and prevention strategies.				X
3. Administered Washington State participation in multi-state CDR database.				X
4. Promoted Washington State's Plan for Youth Suicide Prevention 2009 and its strategies to stakeholders.			X	
5. Participated in the dissemination of the State Injury Prevention & Violence Prevention Guide which includes a chapter on suicide.				X
6. Promoted use of the Harborview Injury Prevention Resource Center web-based tool that describes best practices and recommendations for injury prevention, including youth suicide prevention.			X	
7.				
8.				
9.				
10.				

b. Current Activities

OCHS leads implementation of statewide youth suicide prevention activities. OMCH provides support by promoting programmatic activities, providing links to related activities, and sharing critical data sources.

Recommendations from the Youth Suicide Prevention Program evaluation are incorporated into program planning to the extent possible. The DOH website promotes action in local communities, makes updated data available, and promotes best practices. A listserv is also in place to share information broadly.

OMCH program and assessment staff: participate on the DOH Family Violence Prevention Workgroup; conduct surveillance of suicide deaths through the 18 current local CDR teams; and administer Washington State participation in a multi-state CDR database.

OMCH works with OCHS on activities that are common priorities. We promote the State Injury and Violence Prevention Guide and State Plan for Youth Suicide Prevention and implement their strategies.

OMCH is developing the 2010 Healthy Youth Survey (HYS). OCHS provides partial financial support for questions related to suicide. These include questions on suicidal thoughts, planning, and attempts. It asks about depression; whether the student received information about suicide prevention; and whether the student has an adult to turn to when depressed. OMCH will share results from this survey with stakeholders and partners. The results will be used to promote suicide prevention based on the identified scope of the problem.

c. Plan for the Coming Year

Suicide continues to be the second leading cause of death for adolescents in Washington State. The trends show a decline in the rate of suicide in the past 13 years, however recently this rate is leveling out. We will continue working to maintain this downward trend by implementing strategies from the Washington State Injury & Violence Prevention Guide and Washington State Plan for Youth Suicide Prevention-2009. Reduced resources will present a challenge.

A 1997 Governor's initiative funded planning and implementation of a statewide child death review system. This system was created by DOH, Department of Social and Health Services (DSHS), LHJs, and stakeholders and managed at the state level by DOH and DSHS. From 1998 to 2003 Washington's legislature continued to fund this effort with most of the funding flowing to local health jurisdictions (LHJs) to support local CDR teams. This funding was eliminated in the 2003-2005 Washington State biennial budget and no other funding source has replaced it. Data collected since 2003 is neither comprehensive nor statewide.

OCHS will continue to lead implementation of statewide youth suicide prevention activities in support of the Youth Suicide Prevention Program. OMCH will continue to work with OCHS on common priorities through networking, internally with work groups such as Adolescent Health, DOH Family Violence Prevention, and DOH Injury Prevention.

We will continue to raise awareness and provide educational material on youth suicide. We will work to increase the number of youth-focused groups that adopt programs that address suicide prevention and community mobilization skills of people who develop local suicide prevention programs; the number of people who know where to join youth suicide prevention efforts in their community; and the number of schools that teach about coping with stress, and have policies for connecting students to mental health services. We will continue to share data with local communities in order to show the need for youth suicide prevention.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	86	87	86.1	86.2
Annual Indicator	87.8	85.9	85.8	82.6	
Numerator	604	709	774	754	
Denominator	688	825	902	913	
Data Source				WA Center for Health Statistics	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	86.2	86.3	86.3	86.4	86.4

Notes - 2009
Birth data for 2009 not yet available.

Notes - 2008
PERFORMANCE OBJECTIVES: A combination of trend analyses and discussions were used to create the future objectives. The number of tertiary care hospitals has increased over time leading to improvements in this indicator, but is not expected to increase further. Therefore, an increase of 0.1 every two years was chosen.

The numerator is determined by the number of resident very low birth weight (VLBW) births that occur in-state delivered at a hospital providing perinatal intensive care (Level III). The denominator represents the total number of VLBW resident infants born in-state. The source for this data is the Washington Center for Health Statistics Birth Certificate Files.

Notes - 2007
PERFORMANCE OBJECTIVES: A combination of trend analyses and discussions were used to create the future objectives. The number of tertiary care hospitals has increased over time leading to improvements in this indicator, but is not expected to increase further. Therefore, an increase of 0.1 percent every two years was chosen.

The numerator is determined by the number of resident very low birth weight (VLBW) births that occur in-state delivered at a hospital providing perinatal intensive care (Level III). The denominator represents the total number of VLBW resident infants born in-state. The source for this data is the Washington Center for Health Statistics Birth Certificate Files

a. Last Year's Accomplishments
In 2008, 82.6% of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates. This does not meet our target of 86.2%. This statistically significant drop from the last few years reflects a shifting of resources and specialists between facilities. One facility has opened up a neonatal intensive care unit and recently received approval for their certificate of need.

OMCH continued to monitor and report the delivery sites of very low birth weight babies. This is part of the state perinatal indicators report which is widely distributed to stakeholders.

Maternal, Infant, Child, and Adolescent Health (MICAH) coordinates and supports the statewide Perinatal Regional Networks (PRN). Washington State is covered by four PRNs. Work in each region is lead by a level 3 perinatal facility with at least five years of experience. The PRN coordinators are members of the state Perinatal Advisory Committee (PAC), which also includes representatives from professional organizations and consumer groups. PAC identifies and prioritizes perinatal concerns and needs. PAC recommends prioritized solutions to DOH.

The PRN formed local perinatal advisory committees to develop models for regional quality improvements to promote high quality perinatal and neonatal services.

The Northwest Perinatal Regional Network expanded its Vermont Oxford Neonatal Network, created in 2008 to collect in depth outcome data for very low birth weight infants born in Washington. Ten hospitals are in the consortium and the remaining hospitals are being recruited. Approximately 40% of the births in Washington State occur at the hospitals currently participating in the consortium.

OMCH activities for this performance measure are population based and infrastructure services and are directly related to the MCH priorities of access to treatment services and quality interventions.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Funded Regional Perinatal Networks to coordinate and implement quality improvement projects to improve pregnancy outcomes statewide.				X
2. Monitored delivery sites of very low birth weight babies and advocated for delivery of these infants at tertiary care facilities.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OMCH Assessment continues to monitor and report the delivery sites of very low birth weight babies. Rural Washington State has had an increase of close to 10% in overall birthrate in the last three years. OMCH believes that this increase in areas where pregnant women must travel to level 3 facilities, has directly impacted the percent of very low birth weight infants delivered at non level 3 facilities.

The state perinatal indicators report includes the percent of very low birth weight babies born at appropriate level hospitals. This is presented at the Perinatal Advisory Committee every spring.

PRN continue to work with local advisory committees to develop models for regional quality improvement to promote high quality perinatal and neonatal services. PRNs are also working together on statewide quality improvement projects.

The Northwest PRN consortium continues to collect in depth outcome data for very low birth weight infants born in Washington.

c. Plan for the Coming Year

Increasing the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates is incorporated into the MICAH strategic plan and supports the DOH goal of improving the health of Washingtonians by improving birth outcomes. It also fits within the OMCH program priorities of "Access to preventive and treatment services for the MCH population" and "Quality screening, identification, intervention, and care coordination."

We expect that 2010 rates will reflect an increase back to previous levels if a certificate of need is granted to the new neonatal intensive care unit.

We will continue to monitor this trend and share information with providers. We will continue current activities.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	83	80	81	81	77

Annual Indicator	79.2	78.5	76.3	77.0	
Numerator	54648	59518	61938	64561	
Denominator	69038	75853	81187	83870	
Data Source				WA Center for Health Statistics	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	77	77	77	77	77

Notes - 2009
2009 Birth Certicate data for WA resident births are not yet available.

Notes - 2008
PERFORMANCE OBJECTIVES: A new birth certificate was implemented in 2003. The specificity of the question, which asks for the exact date of prenatal care initiation, has resulted in a high amount of missing data. In 2008, 7.1% of the data was missing for this measure. This is, however, an improvement over past year's percentages

Trend analyses based on data from 2003-2008 indicate a continued decrease in this measure. Additionally, there is a large disparity by Medicaid status. 66.6% of women receiving Medicaid received care beginning in the first trimester compared to 87.0% of women not receiving Medicaid (source First Steps Data Base, Washington State Department of Social and Health Services). The apparent and sustained decrease in the measure has led program staff to believe that decreasing the target to reflect recent data and holding this rate steady is the optimal outcome which can be achieved in the short term given recent cuts to the First Steps program and a lack of avaliablity of providers to take on additional Medicaid patients in some regions of the state.

Further, the National Center for Health Statistics (NCHS) indicates that, “the 2003 revision of the birth certificate introduced substantive changes in item wording and also to the sources of prenatal information….Accordingly, prenatal care data for the two revisions are not comparable.” As a result, trend analysis crossing from 2002-2003 cannot be done. Trends can only be based on six years’ worth of data (2003-2008).

The source for these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October). The numerator is the number of resident live births with a reported first prenatal visit before 13 weeks gestation. The denominator is the total number of resident live births. Missing data are excluded.

Notes - 2007
PERFORMANCE OBJECTIVES: A new birth certificate was implemented in 2003. The specificity of the question, which asks for the exact date of prenatal care initiation, has resulted in a high amount of missing data. In 2007, 8.7% of the data was missing for this measure. This is, however, an improvement over past year's percentages

Trend analyses based on data from 2003-2007 indicate a continued decrease in this measure. Additionally, there is a large disparity by Medicaid status. 65.3% of women receiving Medicaid received care beginning in the first trimester compared to 86.6% of women not receiving Medicaid

(source First Steps Data Base, Washington State Department of Social and Health Services). The apparent and sustained decrease in the measure has led program staff to believe that decreasing the target to reflect recent data and holding this rate steady is the optimal outcome which can be achieved in the short term given recent cuts to the First Steps program and a lack of avaliablity of providers to take on additional Medicaid patients in some regions of the state. It is hoped that future economic conditions will facilliate a return to a positive trend in this measure and this is indicated in an increase of 1% and its maintenance in the 2012-2013 period.

Further, the National Center for Health Statistics (NCHS) indicates that, "the 2003 revision of the birth certificate introduced substantive changes in item wording and also to the sources of prenatal information….Accordingly, prenatal care data for the two revisions are not comparable." As a result, trend analysis crossing from 2002-2003 cannot be done. Trends can only be based on five years' worth of data (2003-2007).

The source for these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October). The numerator is the number of resident live births with a reported first prenatal visit before 13 weeks gestation. The denominator is the total number of resident live births. Missing data are excluded.

a. Last Year's Accomplishments

The 2008 Washington State rate of 77% of infants born to pregnant women receiving prenatal care beginning in the first trimester is below our 81% target. Prenatal care access in Washington has declined since 2002. Declining prenatal care access is related to many factors related to women, providers, and the health care system. One factor is a rising birth rate and a declining number of medical providers performing deliveries. In some communities this is especially true

We have the following activities in place to improve access to prenatal care. These activities fall into the enabling, population based, and infrastructure services levels of the MCH pyramid.

OMCH monitored prenatal care data and distributed it to First Steps providers, included it in the Perinatal Indicators Report, and shared it with the Perinatal Advisory Committee.

Maternal, Infant, Child, and Adolescent Health (MICAH) and First Steps staff worked with communities with the lowest rates of first trimester prenatal care, and/or the greatest disparity between Medicaid and non-Medicaid paid births.

MICAH continued to work with Clark and Pierce counties on projects related to prenatal care access. Our goal is to increase the percent of pregnant women who enter prenatal care in the first trimester. These projects place a special emphasis on African American, Native American, low income, and teenage pregnant women.

MICAH contracted with Tacoma Pierce County Health Department (TPCHD) to provide outreach about First Steps services to African American pregnant women. The contractor works with church leaders as trusted members of the community to improve referrals to First Steps. They also network and provide outreach to community groups that address health issues for communities of color.

MICAH contracted with the American Indian Health Commission (AIHC) to explore ways to address the disparities that exist among pregnant American Indian/Alaska Native women. These disparities include access to prenatal care.

OMCH contracted with local health jurisdictions to provide maternal and child health services, including referrals and linkage to prenatal care. We also monitor prenatal care access data and distributed it to partners.

The WithinReach Family Health Hotline (FHH) referred pregnant women to benefit programs,

including Medicaid, and provided information about prenatal care services. During this period 5,577 pregnant women called FHH. Of these callers, 1,687 were already receiving prenatal care. A total of 7,010 related referrals were given to these callers. OMCH worked with WithinReach to improve awareness of the importance of prenatal care and to help pregnant women access First Steps.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided outreach and education through WithinReach to pregnant women to increase early enrollment in prenatal services.			X	
2. Refer women to Maternity Support Services (MSS) providers for prenatal care if they are not already enrolled and support women to stay in prenatal care.		X		
3. Monitored and shared prenatal care usage data with MSS and perinatal providers.				X
4. Promoted early prenatal care and MSS enrollment to African American women.		X		
5. Explored ways to improve American Indian/Alaska Native prenatal care access.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

All activities described in the Past Accomplishments section are continuing. MICAH is continuing to focus on efforts to decrease poor pregnancy outcomes for populations that are at disproportionately increased risk.

MICAH's work with AIHC is resulting in potential strategies focused on Washington's American Indian/Alaska Native populations. MICAH's work with TPCHD is focusing on outreach to that county's African American population. First Steps and WithinReach are connecting low income women to prenatal services and working to make sure that women know about services that they are eligible for.

WithinReach's FHH and ParentHelp123.org website provide information on the importance of prenatal care services to all pregnant women and to women and families contemplating pregnancy.

MICAH is working with WithinReach to enhance the information for pregnant women on ParentHelp123.org ; implement an on-line tool that pregnant women can use to find First Steps providers near them; educate health care providers about the services WithinReach can provide to their clients, and improve the information about First Steps given out on FHH. They are also doing research to identify possible outreach methods for use in the future.

OMCH is exploring ways to promote Text4Baby, a national initiative that sends free text messages to pregnant women with tips and information on how to have a healthy pregnancy.

We are examining most recent PRAMS data for barriers to access to prenatal care.

c. Plan for the Coming Year
Assuring access to prenatal care is incorporated into MICAH's strategic plan and supports the DOH goal of improving the health of Washingtonians by improving birth outcomes; and reducing post-neonatal and infant deaths, health disparities, and maternal morbidity and mortality. It also fits within the OMCH priority of "Access to preventive and treatment services for the maternal and child population."

Prenatal care access in Washington has declined since 2002, reflected in both decreases in first trimester prenatal care entry access and increases in late or no prenatal care. Medicaid women have lower rates of first trimester entry, and higher rates of late or no prenatal care, than non-Medicaid women. This problem appears to be worsening.

Prenatal care access is a complex issue involving factors related to providers, women, and the system. Examples include inadequate obstetric providers supply, inadequate provider compensation and difficult billing systems. Difficulty navigating the insurance system and women's knowledge about the value and importance of prenatal care are also factors.

DOH has been and will continue working with Medicaid, local communities, and providers to monitor, understand, and develop strategies to address this problem.

OMCH continue to focus on strategies that impact women and provider knowledge and behaviors. We are working to make sure that women are more aware of the importance of prenatal care and are able to access existing programs and resources. We are not able to address the systemic and demographic issues that contribute to the problem, such as insurance, provider supply, and changing birthrate, within existing resources and over a short timeframe. We expect to have an impact on these issues using our current strategies, but only expect to see this impact many years from now.

We will also continue to monitor and share information about the trends related to this issue and work with our partners, including Medicaid, providers, and select local communities, to better understand the trends and identify ways to address its causes. We will also explore actions aimed at addressing related issues.

D. State Performance Measures

State Performance Measure 1: *The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		52	52	52	51
Annual Indicator	51.7	51.0	50.0	50.4	
Numerator	55011	56923	56835	57679	
Denominator	106427	111635	113656	114549	
Data Source				Multiple Sources See field notes	
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	51	51	51	51	

Notes - 2009
Data are not yet avaliable. This measure will be brought forward into the next five year Block Grant cycle.

Notes - 2008
The numerator for this measure is derived from the estimated percentage of unintended pregnancies from Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey *(resident live births + reported resident abortions). The denominator for this measure is the number of resident live births + reported resident abortions. Birth and abortion data are obtained from the Washington State Center for Health Care Statistics Birth, Fetal Death, and Abortion files for 2008. PRAMS 2008 data are used.

Given three years of a slight, but steady downward trend it was decided to lower the annual performance objective by one percent through 2014.

Notes - 2007
The numerator for this measure is derived from the estimated percentage of unintended pregnancies from Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey *(resident live births + reported resident abortions). The denominator for this measure is the number of resident live births + reported resident abortions. Birth and abortion data are obtained from the Washington State Center for Health Care Statistics Birth, Fetal Death, and Abortion files for 2007. PRAMS 2007 data are used.

Given three years of a slight, but steady downward trend it was decided to lower the annual performance objective by one percent through 2013.

a. Last Year's Accomplishments
The unintended pregnancy rate was approximately 50% in 2008 which was better than our target of 52%. This rate includes births and abortions. According to 2008 Pregnancy Risk Assessment Monitoring System (PRAMS) data which looks at live births only, approximately 37% of Washington State births resulted from unplanned pregnancies. The rate is significantly higher for women receiving Medicaid (51%) than for women not receiving Medicaid (23%).
The unintended pregnancy rate has remained constant in Washington State for many years. Unintended pregnancy directly relates to several MCH priorities: Sexually responsible and healthy adolescents and women; Healthy relationships; and Healthy growth and development. Unintended pregnancy is associated with late or no prenatal care, reduced inter-pregnancy interval, substance use, intimate partner violence, and poor birth outcomes such as premature birth, low birth weight. Data on unintended pregnancies was included in the state perinatal indicators report which OMCH shared with stakeholders.

The focus of the following OMCH activities was to increase access to and use of birth control through education and referral to services.

WithinReach provided family planning information and referral assistance to 206 Family Health Hotline (FHH) callers and 3,531 Take Charge line callers.

Twelve new First Steps Maternity Support Services (MSS) providers completed Family Planning web based training modules. The goal of these trainings was to increase provider access to training about family planning interventions for MSS clients. Maternal, Infant, Child, and Adolescent Health (MICAH) MSS providers were required to offer family planning education to all Medicaid clients. MSS staff monitored MSS family planning performance measure billings for compliance with this requirement. Due state legislated budget cuts, the MSS program was revised in 2009. Due to these revisions, MSS providers could no longer bill for the MSS Family Planning performance measure after June 2009.

Although quantitative data on the MSS family planning performance measure was only available through June 2009, family planning education and referrals were provided throughout the reporting period. This included referrals to the Department of Social and Health Service's (DSHS) Take Charge Program. MICAH MSS staff confirmed this through review of a sample of program participant case files.

OMCH collaborated with the Department of Corrections (DOC) and the Prison Doula project to increase reproductive health education and service linkage for female inmates prior to their release. They initiated a plan to help women start taking birth control pills prior to release and provide a three months supply upon release. Data on this project are not yet available.

Maternal, Infant, Child, and Adolescent Health (MICAH) reviewed sexual health education curricula for medical and scientific accuracy. MICAH also responded to public inquires about this issue. We update the curricula list in coordination with the Office of the Superintendent of Public Instruction (OSPI). MICAH provided technical assistance, consultation and capacity around comprehensive sex education.

MICAH provided funding for two school based health centers (SBHC). These SBHC provided comprehensive health care and education to high school students. This includes primary, mental health, and reproductive health services.

OMCH coordinated with the DOH Family Planning and Reproductive Health section (FPRH). FPRH also contracted with local agencies to provide family planning and reproductive health services to low income Washington residents. These services were funded by federal Title X funds and state funds.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increased referrals to family planning services and use of birth control by MSS clients.		X		
2. Provided family planning training to MSS agencies.				X
3. Provided birth control education and referral to family planning services through WithinReach.			X	
4. Worked with Department of Corrections and others to increase education and referrals to inmates prior to release.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

PRAMS data on unintended pregnancy is in the Perinatal Indicators Report. MICAH shared this report with the Perinatal Advisory Committee in May 2010. The data will be posted on the internet and shared with First Steps agencies and local health jurisdictions.

CHILD Profile includes messages about birth spacing and family planning in the 30-day postpartum mailing and a message about birth spacing in the 3-month postpartum mailing. These are sent to women who have delivered a baby in Washington State.

OMCH works with DOC and the Doula Project on reproductive health education and service

linkage for female inmates preparing for their release. We work with the Doula Project to further implement a pilot program to give women a supply of birth control prior to release, an additional family planning session close to release, and a health education and resource packet at release.

MICAH applied for the Tier 1 federal Teenage Pregnancy Prevention Funding targeting middle school youth in rural Washington. We also funds two SBHCs.

WithinReach provides family planning information and referral assistance through FHH, the Take Charge hotline, and ParentHelp123.org. WithinReach began mailing a postcard with useful phone numbers and websites, including birth control and family planning resources, to callers who say they would like it.

MSS supports clients accessing family planning services throughout pregnancy and post-partum.

c. Plan for the Coming Year

Reducing the percent of unintended pregnancies is incorporated in MICAH's strategic plan and supports the DOH goal of improving the health of Washingtonians. It also fits within the OMCH program priority of "Sexually responsible and healthy adolescents and women." The rate of unintended pregnancies has remained fairly constant since 2005.

We anticipate the following changes to current activities:

Implementing the Making Proud Choices curriculum as the result of our application for Tier 1 federal Teenage Pregnancy Prevention Funding. Making Proud Choices is an evidence-based teenage pregnancy prevention program. MICAH plans to implement this curriculum in targeted high risk communities.

MICAH plans to further enhance our teen pregnancy prevention program using new Health Care Reform federal funding for teen pregnancy prevention allotted to states.

If the state Medicaid program obtains federal approval for a proposed state plan amendment, it will include the Take Charge Family Planning program, and will maintain provision of pre-pregnancy planning services for men and women at or below 200% of the federal provider line.

We will continue current activities including:

Exploring ways to increase the number of MSS providers who take and complete the on-line family planning training.

Continuing to help clients access Take Charge.

FPRH will continue to contract with local agencies to provide family planning and reproductive health services to low income Washington residents This will continue to be funded with federal Title X and state funds. Despite an economic environment that has resulted in state funding cuts to many programs, the State Legislature restored funding for this program in its final budget. Prior versions of the budget had contained a significant reduction.

State Performance Measure 5: *Promote the use of Bright Futures materials and principles by health, social service, and education providers in Washington State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		70	85	95	100
Annual Indicator	40	65	80	90	90
Numerator					
Denominator					
Data Source				WA State Child and Adolescent Heatlh Section	WA State Child and Adolescent Heatlh Section
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	

Notes - 2009
PERFORMANCE OBJECTIVES: This new performance measure for the period of 2005-2009, is a process measure which differs from the other measures, which are outcome-oriented. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each year). Since there are 20 benchmarks for the five year period, each benchmark is equivalent to five percentage points; at the end of the five years, 100% of the benchmarks seek to be attained. Each benchmark relates to the use of Bright Futures materials and principles by providers in Washington State.

No new benchmarks were attained in the past year.

Notes - 2008
PERFORMANCE OBJECTIVES: This new performance measure for the period of 2005-2009, is a process measure which differs from the other measures, which are outcome-oriented. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each year). Since there are 20 benchmarks for the five year period, each benchmark is equivalent to five percentage points; at the end of the five years, 100% of the benchmarks seek to be attained. Each benchmark relates to the use of Bright Futures materials and principles by providers in Washington State.

The following new benchmarks have been attained:

Year 4
-Develop plan for ongoing professional oral health trainings, based on the evaluation.
-Assess Bright Futures activities to date and revise the plan in order to continue health promotion activities for the MCH population.

These data are provided by the Office of Maternal and Child Health, Child and Adolescent Health Section of the Washington State Department of Health, Division of Community and Family Health.

Notes - 2007
PERFORMANCE OBJECTIVES: This new performance measure for the period of 2005-2009, is a process measure which differs from the other measures, which are outcome-oriented. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each year). Since there are 20 benchmarks for the five year period, each benchmark is equivalent to

five percentage points; at the end of the five years, 100% of the benchmarks seek to be attained. Each benchmark relates to the use of Bright Futures materials and principles by providers in Washington State. The following new benchmarks have been attained:

Year 3
-Conduct trainings or develop cirricula/materials according to needs identified in assessment.
-Evaluate Bright Futrues oral health trainings.
-Disseminate findings from Foster Parent Mental Health project

a. Last Year's Accomplishments
This measure was chosen because Bright Futures is a tool and a best practice for increasing quality of health care and health education for children and families. By using and promoting Bright Futures, MCH is furthering the goals of MCH Priorities: 1) Adequate nutrition and physical activity, 3) Optimal mental health and healthy relationships, 6) Healthy physical growth and cognitive development, 8) Access to preventive and treatment services, and 9) Quality screening, identification, intervention and care coordination.

The toolkit, Bright Futures Guidebook for Early Childhood Care and Education, was distributed statewide and nationally. Guidebooks were sent out from DOH in response to individual requests, and were distributed at conferences and meetings. Between 2007 and October 2009, 578 guidebooks were sent to groups or individuals who requested them, outside of a specific training.

MICAH used the third edition of Bright Futures Guidelines to train child care health consultants. Bright Futures is presented to child care health consultants as the standard for well-child care, and they pass this information on to child care providers and the public. The American Academy of Pediatrics Bright Futures books were recommended, and the Washington State Early Childhood Toolkit was given, to child care health consultants at their orientations.

The Washington Bright Futures website was a resource for DOH and the public about Bright Futures activities.

Oral Health used Bright Futures Oral Health as the foundation to start a series of simple, evidence-based and tailored oral health education materials for WIC clients, pregnant women, school curriculum, CHILD Profile (a mailing health promotion system that reaches over 450,000 families in the state with children 0-6 years old), and others. The purpose is to enhance consistency of such messages in the state so that families receive the same messages wherever they go in their communities. Bright Futures was used as a foundation because it is considered a neutral and reliable source of oral health information.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training on the use of the Bright Futures guidelines and materials.				X
2. Collaborate with DOH Oral Health staff to develop consistent oral health messages using Bright Futures.			X	
3. Build and maintain Washington Bright Futures Website.				X
4. Present Bright Futures projects at state and national conferences.				X
5. Use Bright Futures guidelines and principles in trainings for child care health consultants, both initial orientation and continuing education.				X

6.				
7.				
8.				
9.				
10.				

b. Current Activities

Oral Health educational materials based on Bright Futures have been reviewed and expanded by local oral health program coordinators, university faculty and field experts. It is expected that all these materials will be completed this year and be disseminated statewide through the funded local oral health programs, via internet or presentations in conferences by the new State Oral Health Promotion Coordinator (funded by HRSA grant 09-109).

Child care health consultants received focused training on the national Bright Futures guidelines and the Early Childhood Project in Washington State at a statewide conference held in April 2010. This conference was attended by 37 child care health consultants. The state coordinator placed emphasis on the differences between the second and third editions of the Bright Futures guidelines, the 10 themes in the new edition, and the many family and child materials available through Bright Futures.

c. Plan for the Coming Year

Bright Futures remains a valuable asset and best practice for increasing quality of health care and health education for children and families. OMCH will continue to use Bright Futures material as reference material and to promote the use of Bright Futures materials within available resources.

Decreases in funding in the federal MCH Block Grant led to the cancellation of a contract with University of Washington. This contract focused on disseminating Bright Futures material through trainings and a website.

Funding decreases have also meant that we are unable to purchase new Bright Futures material for distribution to stakeholders.

Since we are unable to continue these activities we will retire this performance measure beginning with the MCH Block Grant 2012 application/2010 report.

State Performance Measure 6: *Percent of children 6-8 years old with dental caries experience in primary and permanent teeth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		52.2	58	57	56
Annual Indicator	59.0	59.0	59.0	59.0	59.0
Numerator	145873	147801	147801	151331	151331
Denominator	247243	250511	250511	256493	256493
Data Source				Washington State 2005 Smile Survey	Washington State 2005 Smile Survey
Is the Data Provisional				Final	Final

or Final?					
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	54	53	52	

Notes - 2009
PERFORMANCE OBJECTIVES: There are only two years of data available since the Smile Survey is administered every five years. As more data become available, additional analyses will be conducted to determine appropriate future objectives. A gradual decrease of 1% per year through 2014 was chosen.

The source of the data is the 2005 Washington State SMILE Survey, therefore there are no new data for the indicator for 2009. The indicator reflects the proportion of 6-8 year olds with dental caries experience in primary and permanent teeth. The source of the denominator data is the Office of Financial Management Population Forecast. The numerator is calculated from both of these.

Notes - 2008
PERFORMANCE OBJECTIVES: There are only two years of data available since the Smile Survey is administered every five years. As more data become available, additional analyses will be conducted to determine appropriate future objectives. A gradual decrease of 1% per year through 2013 was chosen.

The source of the data is the 2005 Washington State SMILE Survey, therefore there are no new data for the indicator for 2008. The indicator reflects the proportion of 6-8 year olds with dental caries experience in primary and permanent teeth. The source of the denominator data is the Office of Financial Management Population Forecast. The numerator is calculated from both of these.

Notes - 2007
PERFORMANCE OBJECTIVES: There are only two years of data available since the Smile Survey is administered every five years. As more data become available, additional analyses will be conducted to determine appropriate future objectives. A gradual decrease of 1% per year through 2012 was chosen.

The source of the data is the 2005 Washington State SMILE Survey, therefore there are no new data for 2007. The indicator reflects the proportion of 6-8 year olds with dental caries experience in primary and permanent teeth. The source of the denominator data is the Office of Financial Management Population Forecast. The numerator is calculated from both of these.

a. Last Year's Accomplishments
In 2000, 55.6% of children age 6-8 years had dental caries experience in primary and/or permanent teeth. In 2005 (most recent data available), the rate appeared to increase to 59.0%. Data was collected in 2010 and will be available for next year.

The State Oral Health Program worked with the University of Washington School of Dentistry Dental Education and Care for Individuals with Disabilities (DECOD) Program to develop a series of tailored factsheets related to oral health care for children with special needs with minor to moderate chronic conditions. The fact sheets have three versions: for families/caregivers, dental providers, and medical providers.
The State Oral Health Program, through HRSA Grant 09-109, developed the first State Collaborative Oral Health Improvement Plan through partnership with hundreds of partners and stakeholders. These included representatives from the private and public sector, private and public health dentistry, professional associations, academia. Dental providers and the public, including those most affected by dental disease, contributed individual input.

The Oral Health Program funded 35 local oral health programs to support 35 local oral health coalitions. Such coalitions unite different stakeholders and increase community oral health capacity. The Oral Health Program is also a member in the State Oral Health Coalition's Executive Committee. Local oral health coalitions were encouraged to participate in the State Oral Health Coalition as well.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Tailor Oral Health messages to different MCH-related programs (WIC, Head Start, First Steps, schools, etc.) and upon revision make available online in a fact sheet format.				X
2. Implement the Statewide Collaborative Action Plan on Oral Health Access for Children with Special Health Care Needs.			X	
3. Organize two regional forums to bring partners together to implement the TOHSS grant.				X
4. Strengthen state oral health coalition and 32 local oral health coalitions, to help unite the different counties and oral health stakeholders.				X
5. Fund local oral health programs to educate families and MCH-related programs.			X	
6. Maintain website with information on oral health promotion/education and access to dental care.			X	
7. Work with stakeholders to develop the state oral health plan.				X
8. Collect statewide dental caries experience data.				X
9.				
10.				

b. Current Activities

The Oral Health Program continues to fund 35 local oral health programs, support local oral health coalitions, and participate in the State Oral Health Coalition.

The Oral Health Program is implementing the 2010 Smile Survey at the state and county levels. This Survey was created in Washington in the 1990s and is now a national best practice, being used by more than 35 states. Under this survey, oral health screening with accompanying dental referrals are done in pre-schoolers (Head Start), kindergarteners and 3rd graders (based on the indicators set up by Healthy People 2010). This survey looks at caries experience, untreated caries, and presence of sealants. This is the 4th time Washington implements this survey, which has been repeated every 5 years.

c. Plan for the Coming Year

Hands on clinical curricula for dental and medical providers based on the fact sheets for children with special needs will be developed in the next year. Such work is funded by HRSA grant 07-039 in response to the previously developed WA State Plan for Special Populations.

Analysis of the 2010 Smile Survey will be conducted in the coming months. Results of the Smile Survey will be reported to partners, the public, and policy makers.

The State Oral Health Program will be working with the State and Local Oral Health Coalitions to improve their sustainability and take ownership of the implementation of the State Oral Health

Plan.

State Performance Measure 7: *Strengthen statewide system capacity to promote health, safety, and school readiness of children birth to kindergarten entry.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		54	82.8	97.2	100
Annual Indicator	25.2	48.6	86.4	100	100
Numerator					
Denominator					
Data Source				WA State Child and Adolescent Heatlh Section	WA State Child and Adolescent Heatlh Section
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	

Notes - 2009
This is a process measure composed of 28 benchmarks. All 28 benchmarks have already been achieved.

Notes - 2008
This is a process measure (work being accomplished is groundbreaking & harder to quantify), w/ 28 benchmarks (statements describing annual work), weighted ~3.6% each with the goal of 100% attainment by 2010.

In 2008 all 28 benchmarks were attained, including the following new benchmarks:

-Maintain collaborations/partnerships with public and private sectors addressing health, safety and school readiness of children 0-5.

-Disseminate findings from Kids Matter implementation grant.

-Achieve full compliance of statewide users reporting in Healthy Child Care Washington (HCCW) data collection system.

-Develop and implement a plan to reduce barriers/promote strengths in HCCW network to support nurturing relationships and healthy environments in child care.

These data are provided by the Office of Maternal and Child Health, Child and Adolescent Health Section of the Washngton State Department of Health, Division of Community and Family Health.

Notes - 2007
This is a process measure. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each year). There are 28 benchmarks, weighted ~3.6% each with the goal of 100% attainment by 2010.

The following new benchmarks have been attained:

-Provide technical assistance and training to Child Care Health Consultants regarding Kids Matter and implementation activities.

-Identify existing OMCH data that can inform Kids Matter indicators and outcomes.

-Identify system level indicators for components of Kids Matter.

-Communicate health and safety in school readiness efforts based on Kids Matter system level outcomes across OMCH.

-Link Kids Matter indicators and outcomes to OMCH 9 priorities.

-Provide technical assistance and training to users of web-based data collection system for Healthy Child Care Washington (HCCW).

-Identify key HCCW policy messages and dissemination strategies.

-Create and disseminate annual report for Healthy HCCW.

a. Last Year's Accomplishments
This is a process measure with 28 benchmarks. We have accomplished all 28 benchmarks.

SPM07 supports OMCH's role in promoting health, safety, and school readiness. It also supports the Maternal Child Health Bureau's emphasis on systems development and integration through the federal Early Childhood Comprehensive Systems (ECCS) grant. The ECCS grant has five required components: Access to health and medical home; Social-emotional development and children's mental health; Early care and education; Parenting; and Family support. MCH Priorities 1) Adequate nutrition and physical activity, 3) Optimal Mental Health and Healthy Relationships, 4) Health disparities, 5) Safe and healthy communities, 6) Healthy physical growth and cognitive development, 8) Access to preventive and treatment services, and 9) Quality screening, identification intervention, and care coordination are also supported through SPM07.

ECCS and the Kids Matter partnership that developed out of ECCS, focused on increasing systems capacity and integration of early childhood systems and services in Washington. Kids Matter continued to use and refine the outcome-based early childhood plan/framework called Kids Matter: Improving Outcomes for Children in Washington State. Kids Matter's systems-building efforts were further integrated with Washington's Build Initiative efforts. The Build Initiative is supported through the National Build Initiative, an Early Childhood Funders Collaborative. Public and private partners across Washington State developed and have supported the use of this plan.

Kids Matter has provided a framework and strategies to: 1) Improve early childhood outcomes; 2) Increase public will about early learning; and 3) Build and sustain public-private partnerships, increase collaboration and facilitate changes in policies, programs and practices. Examples included: opportunities focused at building public-private partnerships related to Medical Home, Bright Futures, Healthy Child Care Washington (HCCW), Strengthening Families, and early childhood systems capacity.

As a member of the Strengthening Families Washington (SFWA) Steering Committee, Kids Matter has expanded partnerships and funding opportunities linking the Strengthening Families through early care and education approach across state and local agencies. SFWA's theory of change has informed the development of a state work plan and evaluation plan.

The Kids Matter Guidebook has been used to inform strategic planning activities and collaborations across OMCH and assist local early learning community coalitions in systems development efforts.

HCCW and ECCS staff in OMCH, along with the Department of Early Learning (DEL), and other early childhood stakeholders promoted HCCW as a system-level partnership to coordinate policies and practices related to health, safety, and optimal child development in child care, early learning, and after school settings.

CHILD Profile mailed health promotion letters that included age targeted information on school readiness to parents of children aged birth to six years. CHILD Profile also mailed the Getting School Ready booklet, created by Getting School Ready, a project of the Foundation for Early Learning.

Child care health consultants (CCHC) have used Bright Futures and Kids Matter in their work with child care providers, as they work to improve school readiness through quality child care.

Additionally, DOH has a grant from the Substance Abuse Mental Health Services Administration for Project LAUNCH, Linking Actions for Unmet Needs in Children's Health. It supports evidence-based-practices to children birth-8 and their families in one local community, Yakima. LAUNCH work is required to align with ECCS and has built on MHT grant work. LAUNCH staff have worked with the ECCS lead, DOH child and family mental health lead, and key stakeholders to develop a state-level strategic plan.

The Kids Matter framework and related efforts have coordinated with DOH's participation in the Washington State Mental Health Transformation Grant (MHT). Implementation of Kids Matter was a MHT implementation strategy submitted to the Governor's Office by DOH. Activities included identifying priorities for a more coordinated, statewide approach to prevention of mental health challenges.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Make formal presentations regarding Kids Matter to OMCH sections and external early childhood stakeholders.				X
2. Complete Awareness and Utilization Survey of broad early childhood stakeholder group regarding Early Childhood Comprehensive Systems (ECCS) grant and Kids Matter, the partnership and strategic plan/framework that developed from it.				X
3. Use Kids Matter in various grant writing and contract opportunities across OMCH that incorporate the five required components of ECCS and align with the nine OMCH priorities.				X
4. Increase coalition building efforts to expand public-private partnerships and implementation of the Kids Matter strategic plan.				X
5. Integrate strategic planning activities across OMCH using Kids Matter framework.				X
6. Evaluate Kids Matter.				X
7. Integrate Bright Futures Guidelines across components of Healthy Child Care Washington (HCCW) and Kids Matter.				X
8. Encourage the use of the Kids Matter framework at the local level through community mobilization work with partners.				X
9. Support statewide network of child care health consultants.		X		

10.				

b. Current Activities
Kids Matter (KM), DEL, and the public-private partnership, Thrive by Five Washington are creating a new Early Learning Plan (ELP), a statutory requirement of the state Early Learning Advisory Council. It builds on the KM Framework and the Governor's education reform initiative, Washington Learns. We are identifying indicators and outcomes across a Ready framework: Children; parents, families, and caregivers; Early learning professionals; Schools; Systems and communities. ELP emphasizes parent partnership, equity, and local participation.

ECCS is focusing on state and local efforts toward initiatives related to the components of ECCS: Reach Out and Read Washington (ROR-WA)/Health; Project LAUNCH/Social-emotional development and Children's mental health; CCHC/Early care and education; and SFWA/Parenting and family Support.

LAUNCH staff, partners and stakeholders are refining a strategic plan, building on the environmental/financial scan and informing the work of the larger state ELP. Evaluation of LAUNCH will include national cross-site efforts and integration in ECCS and ELP. The LAUNCH coordinator is providing oversight for this grant, including state systems activities and the local community efforts to provide evidence-based interventions. LAUNCH is co-convening a state-level committee to draft a plan for universal developmental screening; linking this work with implementation efforts in Yakima. Developmental screening is one of the 5 key strategies of LAUNCH.

c. Plan for the Coming Year
This state performance measure (SPM07) is being deactivated. The benchmarks set for this measure were fully met last year. A new measure focused on collaboration and coordination of early childhood systems will be added. Through it we will continue to collect and report on OMCH activities that support early childhood development including coordinating the various systems that support this work. The coordination of system aims to provide families with easier access and efficiencies/effectiveness gained from sharing information, using common language, and pursuing common goals.

The previous benchmark targets focused on OMCH activities where the work influenced and supported school readiness. Although OMCH work is critical to school readiness, especially in very young children, we have not traditionally thought of the work and its relationship to school readiness and success. The lessons learned from identifying OMCH activities to promote health, safety, and school readiness showed the need to be very intentional in order to integrate across health, social-emotional development and mental health, early care and education, and parent and family support.

The efforts to meet previous performance measures have helped us to see the critical focus needed on collaboration and partnerships. We plan to focus on collaborations and partnerships that can help influence, leverage, and sustain systems development across early learning. Timing is right as the ECCS grant and OMCH are partnering in the development of a new Early Learning Plan which is being built off of the Kids Matter Framework. Project LAUNCH also provides opportunities for early learning systems development. Collaboration and partnership efforts will focus on: Collaboration with other public agencies and private organizations at the state level; Coordination of components of community-based systems; and Coordination of health services with other services at the community level.

State Performance Measure 8: *Use an established framework for ensuring quality screening, identification, intervention, and care coordination for women, infants, children, adolescents, and their families.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective					100
Annual Indicator				100	100
Numerator					
Denominator					
Data Source				WA State Office of Maternal and Child Health	WA State Office of Maternal and Child Health
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	

Notes - 2009
All quality improvement measures in the OMCH used the established framework.

These data are provided by the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family Health Division.

Notes - 2008
All quality improvement measures in the OMCH used the established framework.

These data are provided by the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family Health Division.

Notes - 2007
No data avaliable as this is a new State Performance Measure.

a. Last Year's Accomplishments
This workgroup distributed the Quality Improvement framework to staff in OMCH, and identified the projects which are beginning to use this framework. These projects included: Early Hearing Diagnosis, Detection and Intervention projects, the Family Health History Pilot, the Perinatal Regional Network Rapid HIV Testing in Labor and Delivery, the Perinatal Advisory Committee Cesarean Section Subcommittee work, the American Indian Health Commission Maternal and Infant Health Subcommittee, the Tacoma Health Department First Steps Outreach to African Americans, the Medical Home Partnership project, the Epilepsy Grant, The Autism Grant, the Developmental Screening Brief, the Neurodevelopmental Center Granting Process, CHILD Profile Mailings, Child Care Health Consultation and Bright Futures.

The workgroup cataloged project activities and linked them to the steps of the framework. This catalog was a reference for future projects, and a tool to determine whether a single performance measure or group of measures could describe all of the quality improvement work related to screening, early identification, intervention and care coordination.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Convene a cross office workgroup to develop a performance measure for the for the Quality Screening, Identification, Intervention, and Care Coordination priority.				X
2. Review quality improvement projects related to screening, identification, early intervention and care coordination.				X
3. Develop a single approach for all quality improvement projects in OMCH related to screening, identification, intervention, and care coordination				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Last year, the workgroup focused on identifying discrete quality improvement projects to implement a uniform approach to quality improvement in the office. The goal was to realize efficiencies and decrease duplication of efforts. Over time the workgroup realized that this effort was not moving us forward in the way we had initially envisioned. We had sought to identify a single measure that would assess our efforts across OMCH focused on improving the quality of screening, identification, intervention, and care coordination. But this measure did not really capture the breadth of efforts.

At the same time, the workgroup realized that work from several different projects and sections in OMCH was coalescing into an office-wide effort to develop and promote universal developmental screening throughout Washington. Such efforts would be best evaluated through a state performance measure on developmental screening. This new approach would reflect the work that we initially envisioned State Performance 08 addressing. For this reason, we are deactivating this measure and replacing it with a new measure focused on outcome measures for universal developmental screening.

c. Plan for the Coming Year
We are discontinuing SPM 08 and replacing it with a new SPM measure focused on outcome measures for universal developmental screening. There are no Plans for the Coming Year for SPM 08.

We are just beginning to work on universal developmental screening. The preliminary plans for that work involve the Children with Special Health Care Needs Program and Maternal, Infant, Child and Adolescent Health Section. Staff from these programs will work together along with staff on the federal autism and LAUNCH grants to develop a vision for a universal developmental screening system in Washington. OMCH will contract with the University of Washington Medical Home Project to assist in convening a statewide Developmental Screening Partnership Committee, comprised of representatives from WA Chapter American Academy of Pediatrics, WA Association of Family Physicians, child care agencies, early learning initiatives, the WA State Department of Early Learning, state Medicaid agency, and other stakeholders to develop a common vision and implementation plan. The Partnership Committee will learn from successful activities in other states in order to create a system unique to Washington State. Initially, we will

monitor this work with the National Survey of Children's Health measure of children 10 months to 5 years whose parents completed a standardized developmental and behavioral screening. Over time, we plan to develop a system that both provides screening tools and helps link families to resources as well as facilitates tracking. Tracking will enable us to evaluate who is being screened, referred, and receiving additional services.

Setting up a comprehensive system that both early education and medical providers use will be complex and take time. It will also take time to change norms and assumptions around developmental screening. We expect to make steady progress toward both these goals. and at the same time anticipate it will be several years before we see improvements in the percent of children screened.

State Performance Measure 9: *Develop an outcome measure for the Washington State maternal and child health priority of Optimal Mental Health and Healthy Relationships.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					60
Annual Indicator				39.9	78.5
Numerator					
Denominator					
Data Source				Washington State Office of Maternal and Child Heal	Washington State Office of Maternal and Child Heal
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	

Notes - 2009
This is a process measure created with the goal of developing an outcome measure. There are 8 benchmarks describing tasks, each variably weighted according to their importance. SPM09 is anticipated to be complete in 2010

Benchmarks with degree of completion:
Complete literature review to identify best practices for achieving specific desirable outcomes. 100% complete

-Identify existing mental health/healthy relationship activities (initiatives) being done in OMCH and identify any new activities that would be appropriate to add. 100% complete

-Determine if OMCH wants to adopt a specific theoretical model for promoting behavior change and use the model to help identify desired outcomes of the identified activities. 100% complete

-Determine short, intermediate, and long term outcomes for each activity. 90% complete

-Identify ways to measure the selected outcome, and if needed, develop the means to collect needed data or information 100% complete.

-Identify the short, intermediate, and long term outcomes for which OMCH has direct or primary influence. 0% complete.

-Develop an evaluation process for mental health and healthy relationship initiatives. 0% complete.

These data are provided by the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family Health Division.

Notes - 2008
This is a process measure created with the goal of developing an outcome measure. There are 8 benchmarks describing tasks, each variably weighted according to their importance. SPM09 is anticipated to be complete in 2010

Benchmarks with degree of completion:

-Complete literature review to identify best practices for achieving specific desirable outcomes. 100% complete

-Identify existing mental health/healthy relationship activities (initiatives) being done in OMCH and identify any new activities that would be appropriate to add. 100% complete

-Determine if OMCH wants to adopt a specific theoretical model for promoting behavior change and use the model to help identify desired outcomes of the identified activities. 50% complete

-Determine short, intermediate, and long term outcomes for each activity. 66% complete

These data are provided by the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family Health Division.

Notes - 2007
No data are avaliable. This is a new State Performance Measure.

a. Last Year's Accomplishments
OMCH worked on developing a new state performance measure (SPM09) for the Optimal Mental Health and Health Relationships priority. Staff from Maternal, Infant, Child, and Adolescent Health (MICAH), Children with Special Health Care Needs (CSHCN) and OMCH Assessment, refined the lists of OMCH activities related to Optimal Mental Health and Healthy Relationships. Activities were sorted in order to identify similar activities whose outcomes could be combined to form a performance measure.

Theoretical frameworks were reviewed and discussed, but the workgroup decided that adopting a framework was not the best use of time and resources for moving toward identifying a measure. Though many activities were identified, the workgroup was not able to find enough commonalities to develop a state performance measure that would reflect the broad work across OMCH.

While OMCH was not able to develop a state performance measure, we were involved in many programmatic activities focused on promoting optimal mental health and healthy relationships.

OMCH represented DOH on the Mental Health Transformation (MHT) Grant Workgroup. Maternal, Infant, Child, and Adolescent Health (MICAH) staff participated on the MHT Prevention Workgroup.

MICAH supported the development of school-based health centers (SBHC), which provide primary care, reproductive health care, and mental health care.

Social, emotional, and mental health was a focus area of the Early Childhood Comprehensive Systems (ECCS) grant. OMCH staff worked with the Department of Early Learning (DEL) and other stakeholders to develop a draft statewide early learning plan. MICAH staff served as the convener for the Social, Emotional, and Mental Health Workgroup that provided draft strategies and priorities for the plan.

DOH received a federal Project LAUNCH grant to promote young child wellness. This builds on and coordinates with ECCS implementation. LAUNCH is working to increase coordination across public agencies and private organizations at the state level and in one local community (as specified by the grant).

OMCH worked with DEL, CCF and other stakeholders to promote mental health consultation to child care and early learning providers. MICAH staff worked with partners to include a strategy related to social, emotional and mental health consultation in the draft statewide early learning plan.

Child care health consultants (CCHCs) provided training and technical assistance regarding social emotional development, to child care providers serving infants and toddler. This is part of the Healthy Child Care Washington (HCCW) initiative administered by MICAH and funded by DEL.

MICAH First Steps staff encouraged First Steps providers to complete the perinatal depression web-training module and implement depression screening for pregnant and post-partum women.

Parents of children aged birth-6 years received age-appropriate mailings via CHILD Profile regarding parenting and child development. Parents of infants also receive information about postpartum depression in their mailings.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participated on the Mental Health Transformation Prevention Advisory Workgroup.				X
2. Supported the development of school-based health centers.				X
3. Implemented the social, emotional and mental health component of the Early Childhood Comprehensive Systems (ECCS) Grant.				X
4. Encouraged First Steps providers to complete the Perinatal depression web-training module collaboratively developed by First Steps and University of Washington.				X
5. Sent parents information on parenting and child development via CHILD Profile health promotion mailings.			X	
6. Promoted social emotional and mental health consultation to child care, early learning providers.			X	
7.				
8.				
9.				
10.				

b. Current Activities

An OMCH workgroup met to develop a state performance measure related to the Optimal Mental Health and Healthy Relationships priority. OMCH staff also discussed the Adverse Childhood Experiences (ACE) Study findings and implications across OMCH, with DOH Community

Wellness and Prevention (CWP), and other stakeholders. In 2009, Washington included the ACE Module in the Behavior Behavioral Risk Factor Surveillance System (BRFSS) for a subset of respondents.

These efforts helped inform the identification of a new state performance measure related the Optimal Mental Health and Healthy Relationships priority: Percent of households with children (0-18yrs) in which the reporting adult has an Adverse Childhood Experience (ACE) score of 3 or more.

OMCH continues to implement ECCS and Project LAUNCH grants, fund school based health centers, mail CHILD Profile information to parents, and work with First Steps providers, DEL and CCHCs as described in the Past Activities section above.

The MHT Grant ends in 2010. MICAH staff is working with MHT Prevention Advisory Group to identify a new administrative home so that partnership can continue.

OMCH will also work with stakeholders to complete the home visiting needs assessment required by new federal legislation.

c. Plan for the Coming Year

We are discontinuing the current SMP 09. A new SPM related to mental health and healthy relationships for Washington will be the percent of households with children (0-18yrs) in which the reporting adult has an Adverse Childhood Experience (ACE) score of 3 or more. OMCH will identify work related to our Optimal Mental Health and Healthy Relationships priority. We will continue to review this work to determine if this state performance measure accurately reflects the effectiveness of that work.

In addition to ongoing work described in the Past and Current Activities section above, OMCH will work with partners in efforts to leverage funding to continue to include the ACE Module in BRFSS and ask the question of more respondents.

OMCH will work with CWP and other DOH partners, state agencies, private organizations, and local communities to identify, prioritize and coordinate efforts related to preventing Adverse Childhood Experiences and reducing negative impacts on the MCH population. OMCH will also work with CWP on the implications of the link between mental health and chronic disease, and the impact of OMCH efforts on chronic disease. These links are informed by the original ACE Study findings. Additional information will be gained from the Washington ACE data.

OMCH will work with partners and stakeholders to submit an application for the home visiting grant that is part of the Federal Health Care Reform legislation. The grant application will be informed by the home visiting needs assessment. This work will be aligned with the statewide Early Learning Plan, ECCS and Project LAUNCH.

State Performance Measure 10: *Identify health disparities, develop and implement interventions to address disparities, and evaluate the effectiveness of interventions in achieving health equity.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance					3

Objective					
Annual Indicator				2.5	2.8
Numerator					
Denominator					
Data Source				WA State Office of Maternal and Child Health	WA State Office of Maternal and Child Health
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	3	3	3	

Notes - 2009
This measure is the average score given by the various participating sections in the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family Health Division. Each section self-evaluated and reported the following scores.

Scale is 1- 3; 3 is the highest score possible.

Genetics 3
CSHCN3
MICAH 3
IPCP 3
Oral Health 2

overall score = 2.8

Notes - 2008
This measure is the average score given by the various participating sections in the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family Health Division. Each section self-evaluated and reported the following scores.

Scale is 1- 3; 3 is the highest score possible.

Genetics – 3
CSHCN – 3
CAH – 2
IPCP – 3
Oral Health – 2
MIH – 2

OMCH average score – 2.5

These data are provided by the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family Health Division.

Notes - 2007
No data are avaliable. This is a new State Performance Measure.

a. Last Year's Accomplishments
The Office of Maternal and Child Health (OMCH) conducted assessments of health equity work for each section. The assessments pointed out areas where sections could improve.

In 2009, the Community and Family Health Division which OMCH is part of began a strategic

planning process. Realizing that health equity issues cut across all of Division's offices and programs, a consideration of health equity became the overarching lens for this strategic planning process.

The Maternal, Infant, Child and Adolescent Health (MICAH) section contracted with the Tacoma Pierce County Health Department (TPCHD) to conduct faith based outreach to African American women. MICAH also contracted with the American Indian Health Commission (AIHC) to explore ways to increase tribal participation in First Steps and to explore best practices for working with American Indian women.

The Immunization Program CHILD Profile (IPCP) section is working with the Asian/Pacific Islander Hepatitis B Coalition to decrease vaccine-preventable disease. This work includes conducting outreach to Asian Pacific Islanders about hepatitis B. IPCP worked with the American Indian Health Commission (AIHC) to develop a tribally driven immunization partnership. The goal of this work is
to improve immunization coverage for American Indians.

Kids Matter worked to develop action oriented steps to reduce disparities.

The Children with Special Health Care Needs (CSHCN) Epilepsy Project promoted medical homes, especially in Hispanic populations in underserved areas of Central Washington. CSHCN program distributed the Tres Familias DVD to providers. This DVD contains the story and challenges faced by three Hispanic families who have a child with a developmental disability.

CSHCN conducted training for families and providers about impacting systems change for families of children with Autism Spectrum Disorder. CSHCN was an active participant in Combating Autism Advisory Council meetings.

MICAH worked with partners to use the Race Matters toolkit to address disparities in early childhood systems. MICAH administered Project Launch, a project designed to address young child wellness in families in an area of the state which that has a higher poverty and a higher percentage of Hispanic and Native American residents than the Washington average. Yakima, Washington, in the central part of the state, is the community that was chosen, through an RFP process, as the site of Project LAUNCH.

The Oral Health Program funded 18 local oral health programs to implement school based dental sealant programs. These programs were specifically targeted to schools that have 30% or more children eligible for free and reduced lunch program. The Oral Health Program is also starting to work with tribes to address their oral health needs. In 2009, the Washington State American Indian Health Care Delivery Plan cited oral health as one of their four priorities. At the same time, the 2009 Washington State Oral Health Plan includes addressing tribal oral health needs in a collaborative manner.

The Early Hearing-loss Detection, Diagnosis, and Intervention (EHDDI) program's assessment of parental demographics of infants lost to follow-up revealed rural young mothers with lower levels of education were least likely to take their infants in for recommended hearing evaluations.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assess disparities and work with target communities to			X	

improve maternal and infant outcomes.				
2. Collaborate on educational and outreach activities to the Asian Pacific Islander, Native American, and African American communities, including community projects and screenings.		X		
3. Coordinate with other organizations and agencies to ensure that adolescents have access to age appropriate and culturally appropriate health services.				X
4. Use the Race Matters Toolkit to view the Early Childhood Comprehensive Systems/Kids Matter work through a racial equity lens and improve results across early childhood systems.				X
5. Improve access to care for children and youth with epilepsy and seizure disorders, especially in the Hispanic population in medically underserved and rural areas of central Washington.				X
6. Engage and empower new stakeholders; coordinate training to providers and families, and impact existing benefit systems for children with special healthcare needs, particularly those with Autism Spectrum Disorder and other developmental disabilities.				X
7. Work with targeted high-need community to promote wellness (physical, social, emotional and behavioral) of young children and families.		X		
8. Implement school based dental sealant programs targeting schools with 30% or more of children eligible for free and reduced lunch program.			X	
9.				
10.				

b. Current Activities

MICAH's work with partners in several areas continues: with the African American community and with AIHC on improving pregnancy outcomes; with the Race Matters toolkit and with Project LAUNCH. MICAH and Public Health Seattle King County are organizing a summit on perinatal health disparities. Maternity Support Services offers maximum level of service to African Americans and Native Americans.

The CSHCN Epilepsy Project continues its work on medical homes. Spanish-speaking Care Coordinators work with the families, providers, and schools to toward a coordinated system of epilepsy care.

CSHCN is training families and providers on impacting systems change for families of children with Autism Spectrum Disorder and distributing the Autism Guidebook as a resource.

IPCP's work with Asian Pacific Islanders on hepatitis B continues. IPCP and AIHC have a planning process to identify ways to address barriers, access, and activities to increase tribal immunization rates.

Oral Health funds a school sealant program pilot. Participating schools need to follow the State Sealant Guidelines and report back on results. At tribal request, Oral Health funds clinical rotations by dental students and residents at tribal dental clinics.

To increase access to hearing screening for rural and Spanish-speaking families, GSS will seek applications from midwives in rural areas to purchase hearing screening equipment, screen babies born out of hospital, and do re-screens needed.

c. Plan for the Coming Year
African Americans and Native Americans are at high risk for poor birth outcomes. MICAH will work with AIHC to address the health disparities among pregnant American Indian and Alaska Native (AI/AN) women and their children. MICAH contracts with AIHC to research and analyze barriers to AI/AN participation in First Steps and identify best practices for tribal and urban delivery of maternal and infant services.

Next year, we will have two SPMs on health disparities. New SPM 07 on infant mortality among Native Americans builds on our work with AIHC. SPM 10, OMCH's internal work on heath disparities, will be continued.

MICAH will continue to work with the Tacoma Pierce County Health Department on outreach to pregnant African American women and with Public Health Seattle King County on a perinatal health disparities summit. Maternity Support Services will offer maximum levels of service to African Americans and Native Americans.

To reduce disparities in child health, Kids Matter will work on action oriented steps to reduce disparities using the Race Matters toolkit. Project Launch will continue its work in Yakima, Washington.

In 2010, the Immunization Program CHILD Profile will initiate the first ever Tribal Health Immunization Workgroup as well as continue our activities with the API Hepatitis B Task Force.

Oral Health has applied for funding to expand its school sealant program to 15-20 more sites. The key component of the expansion will be to implement lessons learned in the school sealant pilot across the state. Improvements in data reporting will be included in our statewide oral health assessment Burden Document.
Oral Health, in conjunction with the University of Washington, School of Dentistry. is taking a lead in workforce development by program is taking a lead in training dental residents in rural and/or underserved urban areas.

Oral Health will work with tribes on school sealants and fluoridation education, to help prevent dental caries.
Oral Health will develop and implement a fluoridation education training statewide to water plant workers and local health jurisdictions.

GSS will select and contract with two midwives in central and eastern Washington to purchase hearing screening equipment, screen babies born out of hospital, and provide re-screens for babies who did not pass their first screen. This will improve access to hearing screens and re-screens for rural and Spanish-speaking families. We will also seek at least one parent guide for the "Guide By Your SideTM" program, a parent support program for families of children diagnosed with or at risk of having hearing loss or deafness. The national Hands and Voices organization developed this program and we are starting to implement it in Washington. The parent guide will need to be bilingual in Spanish and located in eastern Washington.

E. Health Status Indicators
Introduction
DOH staff use raw data to produce reports and other publications, respond to legislative requests, and prepare presentations. Numerous stakeholders and the general public use published documents.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	6.1	6.5	6.3	6.4	
Numerator	5040	5659	5625	5723	
Denominator	82625	86845	88803	90091	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data are not yet available

Notes - 2008
The source for these data are 2008 Natality Table D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

Notes - 2007
The source for these data are 2007 Natality Table D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

Narrative:
The rate of low birth weight for overall births (multiple or singleton) has shown a gradual increase since 1996. However, Washington State continues to have one of the lowest rates for low birth weight in the country.

To promote healthy birth outcomes, First Steps Maternity Support Services (MSS) targets Medicaid eligible pregnant women who are at highest risk for low birth weight. Statewide budget reductions have, in 2010 and will continue in 2011, to impact the percent of women served by these programs.

For more complete information on activities and strategies targeting low birth weight see HSCI 05A, Percent Low Birth Weight <2500g and NPM 17, Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonate .

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	4.7	5.0	4.9	4.7	
Numerator	3765	4213	4197	4136	
Denominator	80109	84081	86098	87104	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data on 2009 WA resident live births not yet available.

Notes - 2008
Data trends have shown relatively flat rates since 1999. The source for these data are 2008 Natality Tables D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

Notes - 2007
Data trends have shown relatively flat rates since 1999. The source for these data are 2007 Natality Tables D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

Narrative:
The rate of low birth weight for singleton births has shown a gradual increase since 1996. Washington State continues to have one of the lowest rates for singleton birth weight in the country.

To promote healthy birth outcomes, First Steps Maternity Support Services (MSS) targets Medicaid eligible pregnant women who are at highest risk for low birth weight. Statewide budget reductions impacted the percent of women served by these programs in 2010 and will continue to in the future.

For more complete information on activities and strategies targeting low birth weight see HSCI 05A, Percent Low Birth Weight <2500g and NPM 17, Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonate.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.9	1.0	1.1	1.1	
Numerator	750	872	965	969	
Denominator	82625	86845	88803	90091	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data on 2009 WA resident live births not yet available.

Notes - 2008
The source for these data are 2008 Natality Table D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

Notes - 2007
The source for these data are 2007 Natality Table D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

Narrative:
Very low birth weight deliveries (singleton or multiple) have remained stable since 1996. Washington State continues to have one of the lowest birth rates for very low birth weight in the country.

To promote healthy birth outcomes, First Steps Maternity Support Services (MSS) targets Medicaid eligible pregnant women who are at highest risk for low birth weight. Statewide budget reductions impacted the percent of women served by these programs in 2010 and will continue to in the future.

For more complete information on activities and strategies targeting low birth weight see HSCI 05A, Percent Low Birth Weight <2500g and NPM 17, Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.7	0.8	0.8	0.8	
Numerator	568	652	721	667	
Denominator	80109	84081	86098	87104	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Data on 2009 WA resident live births not yet available.

Notes - 2008
Singleton VLBW rates show no clear trend and has been very stable since the mid-1990s. The source for these data are 2008 Natality Table D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

Notes - 2007
Singleton VLBW rates show no clear trend and has been very stable since the mid-1990s. The source for these data are 2007 Natality Table D5 reported in the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October).

Narrative:
Very low birth weight deliveries of singletons has remained stable since 1996. Washington State continues to have one of the lowest rates for very low birth weight in the country.

To promote healthy birth outcomes, First Steps Maternity Support Services (MSS) targets Medicaid eligible pregnant women who are at highest risk for low birth weight. Statewide budget reductions impacted the percent of women served by these programs in 2010 and will continue to in the future.

For more complete information on activities and strategies targeting low birth weight see HSCI 05A, Percent Low Birth Weight <2500g and NPM 17, Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.3	6.7	5.6	5.9	
Numerator	92	85	72	76	
Denominator	1259643	1270785	1281739	1295245	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Injury data for 2009 not yet available.

Notes - 2008
The rate is determined by (the number of unintentional injury death among children 14 years and younger divided by children ages 14 years and under). The numerator is provided by the Washington State Department of Health Injury and Violence Program. Data were accessed via the Community Health Assessment Tool (CHAT).

Notes - 2007
The rate is determined by (the number of unintentional injury death among children 14 years and younger divided by children ages 14 years and under). The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

Narrative:
There has been a significant and steady downward trend in the death rate of children 14 years and younger since 2004.

Major activities included disseminating child passenger safety information to parents statewide through CHILD Profile; reviewing unexpected deaths of children through local Child Death

Review (CDR) teams; conducting surveillance of motor vehicle crash deaths to children through CDR process and disseminated data and collaborating with DOH Office of Community Health Systems to promote statewide injury prevention activities.
(Maternal Infant Child and Adolescent Health) MICAH's Injury Prevention liaison works with (Maternal Child Health Assessment) MCHA and the DOH Office of Community Health Systems (OCHS) -- EMS-Trauma and Injury and Violence Prevention sections. MICAH and MCHA staff are on the DOH Injury Prevention and Family Violence Prevention Workgroups. OMCH funds some of OCHS's injury prevention work.

For more information on OMCH activities to reduce fatal unintentional injuries see NPM 10, The rate of deaths to children aged 14 years or younger caused by vehicle crashes per 100,000 children.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.1	1.7	2.0	1.1	
Numerator	39	21	26	14	
Denominator	1259643	1270785	1281739	1295245	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Injury data for 2009 not yet available.

Notes - 2008
The rate is determined by calculating the number of unintentional injury deaths among children 14 years and younger due to motor vehicle crashes divided by the number of children age 14 years and under. The numerator is provided by the Washington State Department of Health Injury and Violence Program. Data were accessed via the Community Health Assessment Tool (CHAT).

Notes - 2007
The rate is determined by calculating the number of unintentional injury deaths among children 14 years and younger due to motor vehicle crashes divided by the number of children age 14 years and under. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

Narrative:
There has been a significant downward trend in the death rate for children 14 years and younger due to motor vehicle crashes since 1998.

Major activities included disseminating child passenger safety information to parents statewide through CHILD Profile; reviewing unexpected deaths of children through local Child Death

Review (CDR) teams; conducting surveillance of motor vehicle crash deaths to children through CDR process and disseminated data and collaborating with DOH Office of Community Health Systems to promote statewide injury prevention activities. (Maternal Infant Child and Adolescent Health) MICAH's Injury Prevention liaison works with (Maternal Child Health Assessment) MCHA and the DOH Office of Community Health Systems (OCHS) -- EMS-Trauma and Injury and Violence Prevention sections. MICAH and MCHA staff are on the DOH Injury Prevention and Family Violence Prevention Workgroups. OMCH funds some of OCHS's injury prevention work.

For more information on OMCH activities to reduce fatal unintentional injuries see NPM 10, "The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children".

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	17.8	21.7	17.9	13.2	
Numerator	160	200	168	125	
Denominator	898864	921059	938320	946777	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Injury data for 2009 not yet available.

Notes - 2008
The rate is determined by the number of unintentional injury deaths among children ages 15 to 24 years divided by the number of children age 15 to 24 years. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. Data were accessed via the Community Health Assessment Tool (CHAT).

Notes - 2007
The rate is determined by the number of unintentional injury deaths among children ages 15 to 24 years divided by the number of children age 15 to 24 years. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

Narrative:
There has been a significant downward trend since 1998 in the rate of death due to motor vehicle crashes in youth 15 to 24 years of age.

Major activities included disseminating child passenger safety information to parents statewide through CHILD Profile; reviewing unexpected deaths of children through local Child death Review (CDR) teams; conducting surveillance of motor vehicle crash deaths to children through CDR process and disseminated data and collaborating with DOH Office of Community Health Systems to promote statewide injury prevention activities. (Maternal Infant Child and Adolescent Health)

MICAH's Injury Prevention liaison works with (Maternal Child Health Assessment) MCHA and the DOH Office of Community Health Systems (OCHS) -- EMS-Trauma and Injury and Violence Prevention sections. MICAH and MCHA staff are on the DOH Injury Prevention and Family Violence Prevention Workgroups. OMCH funds some of OCHS's injury prevention work.

For more information on OMCH activities to reduce fatal unintentional injuries see NPM 10, The rate of deaths to children aged 14 years or younger caused by vehicle crashes per 100,000 children.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	180.2	162.9	157.1	170.3	
Numerator	2271	2070	2014	2206	
Denominator	1260009	1270785	1281739	1295245	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Injury data for 2009 not yet available.

Notes - 2008
The rate is determined by (the number of nonfatal injuries among children 14 years and younger divided by children ages 14 years and under). The numerator is gathered from the Washington State Department of Health Injury and Violence Program. Data were accessed via the Community Health Assessment Tool (CHAT).

Notes - 2007
The rate is determined by (the number of nonfatal injuries among children 14 years and younger divided by children ages 14 years and under). The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

From 1999 - 2003, the non-fatal hospitalization rate for children and youth ages 0-14 declined significantly. However, in 2004 and 2005, the rates were higher than in 2002 and 2003. In 2007 the rates showed a decline for the second year in a row, below the 2004 rate and approximating the 2003 rate.

Narrative:
There has been a significant downward trend since 1998 in the rate of nonfatal unintentional injuries in children 14 years and younger.

Major activities included disseminating child passenger safety information to parents statewide through CHILD Profile; reviewing unexpected deaths of children through local Child Death

Review (CDR) teams; conducting surveillance of motor vehicle crash deaths to children through CDR process and disseminated data and collaborating with DOH Office of Community Health Systems to promote statewide injury prevention activities. (Maternal Infant Child and Adolescent Health) MICAH's Injury Prevention liaison works with (Maternal Child Health Assessment) MCHA and the DOH Office of Community Health Systems (OCHS) -- EMS-Trauma and Injury and Violence Prevention sections. MICAH and MCHA staff are on the DOH Injury Prevention and Family Violence Prevention Workgroups. OMCH funds some of OCHS's injury prevention work.

For more complete information on OMCH activities to reduce unintentional injuries see NPM 10, The rate of deaths to children aged 14 years or younger caused by vehicle crashes per 100,000 children.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	19.4	17.2	13.9	16.6	
Numerator	244	218	178	215	
Denominator	1259643	1270785	1281739	1295245	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Injury data for 2009 not yet available.

Notes - 2008
The rate is determined by the number of nonfatal injuries due to motor vehicle crashes among children 14 years and younger divided by the population of children ages 14 years and under. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. Data were accessed via the Community Health Assessment Tool (CHAT).

Notes - 2007
The rate is determined by the number of nonfatal injuries due to motor vehicle crashes among children 14 years and younger divided by the population of children ages 14 years and under. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

Narrative:
There has been a significant downward trend since 1998 in the rate of nonfatal unintentional injuries due to motor vehicle crashes in children 14 years and younger.

Major activities included disseminating child passenger safety information to parents statewide through CHILD Profile; reviewing unexpected deaths of children through local Child Death Review (CDR) teams; conducting surveillance of motor vehicle crash deaths to children through CDR process and disseminated data and collaborating with DOH Office of Community Health

Systems to promote statewide injury prevention activities. (Maternal Infant Child and Adolescent Health) MICAH's Injury Prevention liaison works with (Maternal Child Health Assessment) MCHA and the DOH Office of Community Health Systems (OCHS) -- EMS-Trauma and Injury and Violence Prevention sections. MICAH and MCHA staff are on the DOH Injury Prevention and Family Violence Prevention Workgroups. OMCH funds some of OCHS's injury prevention work.

For more complete information on OMCH activities to reduce unintentional injuries see NPM 10.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	113.5	106.0	95.3	81.2	
Numerator	1020	976	894	769	
Denominator	898864	921059	938320	946777	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009
Injury data for 2009 not yet available.

Notes - 2008
The rate is determined by the number of nonfatal injuries due to motor vehicle crashes among children age 15 through 24 divided by the population of children age 15 through 24. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. Data were accessed via the Community Health Assessment Tool (CHAT).

2008 data show a continuing downward trend after a spike in the rate which culminated in 2005.

Notes - 2007
The rate is determined by the number of nonfatal injuries due to motor vehicle crashes among children age 15 through 24 divided by the population of children age 15 through 24. The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is gathered from the Office of Financial Management Population Forecast.

2007 data show a continuing downward trend after a spike in the rate which culminated in 2005.

Narrative:
There has been a significant downward trend since 1998 in the rate of nonfatal unintentional injuries due to motor vehicle crashes in youth 15 to 24 years of age.

Major activities included disseminating child passenger safety information to parents statewide through CHILD Profile; reviewing unexpected deaths of children through local Child Death Review (CDR) teams; conducting surveillance of motor vehicle crash deaths to children through CDR process and disseminated data and collaborating with DOH Office of Community Health

Systems to promote statewide injury prevention activities. (Maternal Infant Child and Adolescent Health) MICAH's Injury Prevention liaison works with (Maternal Child Health Assessment) MCHA and the DOH Office of Community Health Systems (OCHS) -- EMS-Trauma and Injury and Violence Prevention sections. MICAH and MCHA staff are on the DOH Injury Prevention and Family Violence Prevention Workgroups. OMCH funds some of OCHS's injury prevention work.

For more complete information on OMCH activities to reduce unintentional injuries see NPM 10 The rate of deaths to children aged 14 years or younger caused by vehicle crashes per 100,000 children.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	22.7	21.1	21.3	23.3	24.0
Numerator	4990	4717	4859	5353	5504
Denominator	219516	223862	227994	229650	229115
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The data, numerator, denominator and rate are provided by the Washington State Department of Health, Office of Infectious Disease and Reproductive Health.

Notes - 2008
The rate is determined by the number of women age 15 through 19 with a reported case of Chlamydia divided by the population of women age 15 through 19. The data, numerator, denominator and rate are provided by the Washington State Department of Health, Office of Infectious Disease and Reproductive Health

Notes - 2007
The rate is determined by (the number of women ages 15 through 19 with a reported case of Chlamydia divided by women aged 15 through 19). The data, numerator, denominator and rate are provided by the Washington State Department of Health, Office of Infectious Disease and Reproductive Health

Narrative:
The incidence rate for Chlamydia for 15 to 19 year old females was stable from 2004 through 2007, but showed an increase in 2008 which continued in 2009, albeit at a more moderate pace. Some of this increase is due to more aggressive case reporting investigations and to better laboratory surveillance, but it may also reflect a very slight increase in actual morbidity.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.3	7.1	7.7	8.4	8.5
Numerator	7960	7857	8545	9375	9573
Denominator	1089135	1102129	1113192	1120549	1125554
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The data, numerator, denominator and rate are provided by the Washington State Department of Health, Office of Infectious Disease and Reproductive Health

Notes - 2008
The rate is determined by the number of women age 20 through 44 years with a reported case of Chlamydia divided by the population of women age 20 through 44 years. The data, numerator, denominator and rate are provided by the Washington State Department of Health, Office of Infectious Disease and Reproductive Health.

Notes - 2007
The rate is determined by (the number of women ages 20 through 44 years with a reported case of Chlamydia divided by women aged 20 through 44 years). The data, numerator, denominator and rate are provided by the Washington State Department of Health, Office of Infectious Disease and Reproductive Health

Narrative:
The incidence rate for Chlamydia for 20 to 44 year old females was stable from 2004 through 2007, but showed an increase in 2008 which appears to have leveled off in 2009. Some of this increase is due to more aggressive case reporting investigations and to better laboratory surveillance, but it may also reflect an actual very slight increase in actual morbidity.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	85673	67084	3900	1748	5063	574	7304	0
Children 1 through 4	347673	273578	16083	7328	21840	2382	26462	0
Children 5 through 9	427189	342130	19787	9369	25669	2994	27240	0
Children 10 through 14	434711	352067	19564	10005	26524	2979	23572	0

Children 15 through 19	472124	381826	20059	10245	33847	3547	22600	0
Children 20 through 24	474654	383081	21412	9443	38540	3850	18328	0
Children 0 through 24	2242024	1799766	100805	48138	151483	16326	125506	0

Notes - 2011

Narrative:
The reason no trend can be calculated is because these are categorical data and data are not measured over time.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	68252	17421	0
Children 1 through 4	284504	63169	0
Children 5 through 9	354451	72738	0
Children 10 through 14	375062	59649	0
Children 15 through 19	413205	58919	0
Children 20 through 24	408841	65813	0
Children 0 through 24	1904315	337709	0

Notes - 2011

Narrative:
The reason no trend can be calculated is because these are categorical data and data are not measured over time.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	74	59	5	6	0	0	4	0
Women 15 through 17	2041	1645	76	97	51	25	147	0
Women 18 through 19	5097	4129	277	194	112	56	329	0
Women 20 through 34	67671	55077	2763	1224	5513	780	2314	0

Women 35 or older	13550	10638	497	134	1868	110	303	0
Women of all ages	88433	71548	3618	1655	7544	971	3097	0

Notes - 2011

Narrative:
The reason no trend can be calculated is because these are categorical data and data are not measured over time.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	31	43	0
Women 15 through 17	1196	845	0
Women 18 through 19	3638	1459	0
Women 20 through 34	55892	11779	0
Women 35 or older	11838	1712	0
Women of all ages	72595	15838	0

Notes - 2011

Narrative:
The reason no trend can be calculated is because these are categorical data and data are not measured over time.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	475	371	31	12	30	8	23	0
Children 1 through 4	88	57	9	5	6	2	9	0
Children 5 through 9	46	36	2	2	4	0	2	0
Children 10	56	41	6	0	5	0	4	0

through 14								
Children 15 through 19	214	170	15	8	7	3	11	0
Children 20 through 24	366	293	14	22	16	8	13	0
Children 0 through 24	1245	968	77	49	68	21	62	0

Notes - 2011

Narrative:
The reason no trend can be calculated is because these are categorical data and data are not measured over time.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	371	104	0
Children 1 through 4	72	16	0
Children 5 through 9	42	4	0
Children 10 through 14	52	4	0
Children 15 through 19	179	35	0
Children 20 through 24	316	50	0
Children 0 through 24	1032	213	0

Notes - 2011

Narrative:
The reason no trend can be calculated is because these are categorical data and data are not measured over time.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children	1767550	1416685	79393	38695	112943	12476	107358	0	2008

0 through 19									
Percent in household headed by single parent	24.9	32.1	41.8	61.8	20.3	17.5	32.9	0.0	2008
Percent in TANF (Grant) families	8.2	4.2	29.3	29.0	6.4	0.0	0.0	0.0	2008
Number enrolled in Medicaid	440103	306478	58686	36222	38717	0	0	0	2008
Number enrolled in SCHIP	21359	11647	464	476	1300	0	3213	4259	2007
Number living in foster home care	9334	4891	1690	2332	421	0	0	0	2008
Number enrolled in food stamp program	231849	152423	39595	22495	17336	0	0	0	2008
Number enrolled in WIC	268930	191643	17421	6504	9451	4381	39530	0	2009
Rate (per 100,000) of juvenile crime arrests	4236.0	4832.0	8519.0	5432.0	1628.0	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	5.1	4.5	7.8	10.1	3.0	6.8	0.0	7.4	2009

Notes - 2011
These data come from the 2008 Washington Population Survey. This survey is conducted every two years. Data reported is from 2008. No new data for 2009 is available.

DSHS Client Services have changed the way they report racial categories. No multiple race category is available. There are no unknowns in their data reporting.

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As of June 2010 DSHS Client Services database is unable to extract the number of kids enrolled in SCHIP program. Latest data from 2007 is being reported until situation can be rectified

DSHS Client Services have changed the way they report racial categories. No multiple race category is avalible. There are no unknowns in their data reporting.

No data on children reporting more than one race is avaliable.

DSHS Client Services have changed the way they report racial categories. No multiple race category is available. There are no unknowns in their data reporting.

Narrative:

The reason no trend can be calculated is because these are categorical data and data are not measured over time.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1495474	271896	0	2008
Percent in household headed by single parent	24.5	27.0	0.0	2008
Percent in TANF (Grant) families	7.0	14.8	0.0	2008
Number enrolled in Medicaid	498443	170919	0	2008
Number enrolled in SCHIP	12812	4865	3682	2007
Number living in foster home care	8393	1784	0	2008
Number enrolled in food stamp program	248476	92763	0	2008
Number enrolled in WIC	165171	103759	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	0.0	7.2	0.0	2009

Notes - 2011
These data come from the 2008 Washington Population Survey. This survey is conducted every two years. Data reported is from 2008. No new data for 2009 is avaliable.

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DSHS Client Services have changed the way they report racial categories. No multiple race category is avalible. There are no unknowns in their data reporting.

Data on juvenile crime arrests distribute Hispanics according to their race. There are no Hispanic specific data avaliable on juvenile arrests. Most Hispanics are included in the White racial category.

DSHS Client Services have changed the way they report racial categories. No multiple race category is avalible. There are no unknowns in their data reporting.

Narrative:

The reason no trend can be calculated is because these are categorical data and data are not measured over time.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1167447
Living in urban areas	14016585
Living in rural areas	171691
Living in frontier areas	124554
Total - all children 0 through 19	14312830

Notes - 2011

Narrative:
The reason no trend can be calculated is because these are categorical data and data are not measured over time.

For a map of Washington State's general population density, see attachment to section IIIA, State Overview.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	6587600.0
Percent Below: 50% of poverty	9.5
100% of poverty	17.7
200% of poverty	33.5

Notes - 2011
Number obtained from OFM September 2009 population forecast

Narrative:
The reason no trend can be calculated is because these are categorical data and data are not measured over time.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total

Children 0 through 19 years old	1766429.0
Percent Below: 50% of poverty	11.2
100% of poverty	21.7
200% of poverty	40.8

Notes - 2011
Number obtained from OFM September 2009 population forecast

Narrative:
The reason no trend can be calculated is because these are categorical data and data are not measured over time.

F. Other Program Activities

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

CHILD Profile Health Promotion mailings remind parents of recommended EPSDT and immunization visits. The 17 mailings are sent to parents of kids aged birth to six years and are timed to American Academy of Pediatrics' well-child visits. CHILD Profile includes a health and development booklet for parents to keep track of EPSDT/well-child checkup information. The booklet is inserted in over 129,000 CHILD Profile mailings per year.

Child Development Charts

Three child development charts are mailed to 262,334 parents per year. The charts address five areas of the Washington State Early Learning and Development Benchmarks. In addition to being mailed to parents, they are available to the public through an online ordering system. In 2009, IPCP partnered with DEL to mail 7400 development charts directly to licensed child care providers.

Billing and Reimbursement for Genetic Services Project

Poor reimbursement for genetic services has been recognized as a national problem. With funding from the Western States Genetic Services Collaborative (WSGSC), Genetic Services Section staff gathered billing data and conducted key informant interviews with genetic counselors and billing personnel to characterize billing and reimbursement practices for genetic services in Washington State. The analysis, in progress, may uncover barriers and opportunities that Washington genetic clinic staff can address to improve reimbursement.

Action Plan for Oral Health and Children with Special Health Care Needs (CSHCN)

In 2007, OHP received a three year federal TOHSS grant to improve access to oral health services for CSHCN with minor to moderate chronic conditions and eligible for Medicaid and State Children's Health Insurance Program. The funding was used to implement a part of the Action Plan for Oral Health and CSHCN. We developed forty-five fact sheets related to oral health for CSHCN. The fact sheets cover 18 different chronic conditions included autism and epilepsy. Each condition has 3 fact sheets: for parents/caregivers, dental providers and medical providers. This is a very comprehensive effort and has no parallel nationwide.

First Steps Redesign Project

MPA and DOH worked with providers to redesign the First Steps Program effective July 1, 2009. The revisions were in response to a legislative directive to implement a 20% program budget reduction and refocus services on women at highest risk for poor birth outcomes, as defined by low birth weight and preterm birth rates. The redesign included determining a client's level of service based on the results of prenatal and post pregnancy screenings for targeted risk factors. Data and an extensive literature review informed the selection of the targeted risk factors. Quality improvement projects that focus on interventions and client outcomes will be initiated in the future.

WithinReach and the Family Health Hotline

WithinReach is a private, not-for-profit organization that connects Washington families to health and food resources, and promotes public awareness and education about specific health issues. DOH sponsor's WithinReach's Family Health Hotline, Washington's maternal and child health hotline. This hotline provides eligibility screening and referrals to Medicaid, WIC, and other programs. It also provides referrals and health education information about pregnancy, prenatal care, maternity support, childbirth, immunizations, family planning, and breastfeeding.

WithinReach also runs toll-free hotlines for children's health insurance information, family planning, and food insecurity. They also maintain ParentHelp123.org, a website that provides families an easy application process for state-sponsored health and food programs, connects families to resources in their community, and provides health information for pregnant women and families. DOH supports three statewide health coalitions run by WithinReach to promote public health awareness and education: the Immunization Action Coalition, Hepatitis B Coalition, and Breastfeeding Coalition.

Since 2008 MICAH has been working with WithinReach to improve tools pregnant women can use to get information and connect to programs and resources. We've added information about prenatal care, making health choices during pregnancy, breastfeeding, birth control after pregnancy, and related topics to the WithinReach website. A new search tool helps users find Maternity Support Services providers by zip code. We are also increasing outreach about WithinReach to providers who may refer their clients to it. (withinreachwa.org)

H1N1 efforts related to pregnant women and deliveries

MICAH developed two fact sheets related to H1N1 (swine flu) and pregnancy. The provider fact sheet contains information and resources for practice preparation and patient care. The fact sheet for pregnant women includes information about home preparation, protection against flu, planning for special needs during pregnancy, and links to additional resources. We also implemented enhanced surveillance of pregnant women hospitalized with H1N1 or maternal deaths related to H1N1

OMCH Publications

MCH Assessment works with the other OMCH programs and external partners to write data reports, assessments and monographs useful in planning and operating maternal and child health programs. Many publications on issues of importance to the MCH population are available in print or via the internet site. Attached is an annotated list, with hyperlinks to DOH's Website, of recent OMCH publications which may interest public health stakeholders and policy makers nationwide.

An attachment is included in this section.

G. Technical Assistance

1. General Systems Capacity Issues

- a.Cultural Competency

OMCH wants to provide training at four Children with Special Health Care Needs (CSHCN) regional meetings to local health jurisdiction (LHJ) providers on culturally competent ways to interview families of CSHCN. A training goal is to improve the quality of data on ethnicity, education, and income levels that local CSHCN providers collect from families. This will support program development. We need a trainer who can teach culturally competent interviewing strategies related to CSHCN and their families.

b. Genetics Services

Inadequate reimbursement for genetic services can limit access to them. In June 2009, the Genetic Services Section (GSS) held a forum for private and public payers, and genetic service providers (clinical and laboratory), to discuss billing and reimbursement for genetic services. We used the funding assistance to bring in participants from remote areas of the state. This meeting provided the foundation for 3 cost/utility studies on emerging gene testing options to be conducted through the University of Washington Center for Genomics Healthcare Equality.

c. Adoption

GSS will request funds to provide training to Washington State prenatal, pediatric and genetic service providers and adoption agency personnel about genetics issues in adoption. These include factors to consider before adoption for both prospective parents and for parents choosing to release their children for adoption. The Director and the Research Coordinator for the Office of Foster Care and Adoption at the University of Massachusetts Medical School will conduct the training.

d. Maternal, Infant, Children and Adolescent Health (MICAH)

The MICAH section received funding from MCHB to conduct a training for child care health consultants. Thirty-seven people from 27 agencies, mostly LHJs attended. Attendees received the new American Academy of Pediatrics, Medication Administration for Early Education and Child Care Settings training. It is a train-the-trainer model of teaching non-health professionals such as child care providers, how to safely use, store, and record medications.

Nine new consultants took classes based on the National Training Institute model with modules on consultation skills, cultural competency, childhood disease, Bright Futures, resource and referral, and CSHCN. There were more advanced sessions on environmental health, health literacy, nutrition and physical activity, the State Early Learning Plan, pandemic flu, and the importance of the Adverse Childhood Experiences Study (ACES). We distributed the new edition of the Bright Futures Guidelines.

The conference met the goal of providing specialized education to new child care consultants. Participants rated most sessions as "good" or "very good".

e. Oral Health Funding Formula

In 2008, the Oral Health Program convened a group of local oral health experts to develop a new funding allocation formula to support oral health activities in LHJs. A collaborative approach to

developing a funding formula is the Public Health Improvement Partnership Funding Allocation Review Process and Allocation Principles. TA funds supported travel and expenses attendees meetings and helped achieve a true collaborative experience. The new funding formula was implemented for the 2009-2010 biennium.

f.Smile Survey

The Oral Health Program has provided training and technical assistance to the implementation of the 2010 Smile Survey. This survey is a dental screening for children in Head Start, kindergarten, and third graders. Data from the survey of children's oral health will drive program planning at the state and local level to improve the oral health of children.

g. CSHCN Public Health Nursing Outcomes

The CSHCN Program wants to collect outcomes on the services provided to children with special health care needs and their families by local public health nurses. They will use problems identified through the Omaha System framework and align them with the CSHCN national performance measures. TA Assistance has been requested for Karen Monsen, PhD, MS, RN, a national expert on the Omaha System, to facilitate six monthly conference calls and provide expert consultation to the 39 CSHCN Public Health Nurses. Dr. Monsen will also be asked to provide input on methods of data collection and data analysis.

h. Local Health Jurisdictions (LHJs)

OMCH contracts with 35 LHJs to address maternal and child health needs in local communities. The LHJ Activity Plan and Statement of Work are the mechanisms we use to describe local options for using these funds, track which activities each LHJ is performing, and collect data on them. They also form the basis for billing.

The LHJ Activity Plan and Statement of Work were last revised prior to 2001. OMCH needs to update the LHJ Activity Plan and Statement of Work to align with OMCH priorities and performance measures, reduce duplication of effort, and increase the relevance of data collected.

We will request assistance to convene a workgroup consisting of OMCH staff and representatives from LHJs. This workgroup would work collaboratively to revise these documents and the systems around them. The result will be a stronger, more efficient partnership for delivering MCH programs statewide.

2. State Performance Measure Issues

3. National Performance Measure Issues

a.Immunization Rates

IPCP used funds to have local and national immunization experts train over 40 local health Perinatal Hepatitis B Coordinators from across the state on how to improve perinatal hepatitis B immunization rates for children and adults. The experts included Lisa Jacques Carroll, CDC Perinatal Hepatitis B Coordinator, and staff from a local hospital and an LHJ. It is too early to see a change in perinatal hepatitis B immunization rates.

b.Vaccine Hesitancy

IPCP may request funding to hold immunization training events for community partners, local health, and stakeholders to increase immunization rates and address parent immunization hesitancy.

c.Child Death Review Teams

This request relates to NPM10 on child deaths in motor vehicle crashes and NPM16 on youth suicide deaths. OMCH will request funds for 2011 to train local Child Death Review Teams (CDR), for whom training is a priority. Local CDR Teams provide surveillance and collect data from child death reviews. Their recommendations to local officials and groups inform strategies to reduce motor vehicle crashes and suicide. Developing skills in how to interpret data, develop strategies, and engage the community will make teams more effective

TA funds supported staff training in 2007 and a State CDR Conference in 2009. The 2007 training focused on the transition to use of the national CDR data system. The 2009 conference had sessions on doll reenactment in Infant Death Investigations, data issues and best practices for CDR Teams and prevention recommendations.

OMCH plans to request funding for a 2011 CDR Conference.

4. Data Related Issues

a. Western Regional MCH Epidemiology Conference

The annual MCH Epidemiology conference is always held in the Southeast US (e.g. Florida or Georgia). MCH epidemiology staff from the Western US, particularly the Northwest, have difficulty traveling that far. This makes maintaining skills in needs assessment and in MCH epidemiology difficult. OMCH requests that MCHB fund and promote a western regional MCH epidemiology conference.

b. Qualitative Assessment and Analysis

OMCH plans to request funding for training and technical assistance to family organizations to increase their capacity to survey and assess quality of life issues they work to improve. For example, staff from Fathers Network want to develop a valid survey tool to measure the impact on the relationships with partners and children of men who regularly participate in Fathers Network activities.

c. Qualitative Research Methods

OMCH needs to continue to build capacity and expertise in qualitative research methods. The MCH Assessment (MCHA) section has increasingly been asked to use and provide technical assistance on qualitative methods to complement quantitative methods or as stand-alone methods in planning program-specific evaluations and OMCH needs assessments.. Most of the staff in MCHA has expertise solely in quantitative methods. MCHA is requesting TA funds for staff training to build internal capacity related to conducting qualitative evaluation.

MCHA staff needs funds for training on how to interface Office products with SAS and STATA to produce reports. This will save precious staff time and provide timely data reports for key MCH stakeholders.

MCHA staff needs funds for training on how to use Geographic Information System to produce accurate maps and reflect all forms of geographically needed information on various risk factors and diseases relevant to MCH population.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	8978733	8855063	9012210		9002043	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	7573626	34500611	7573626		7573626	
4. Local MCH Funds *(Line4, Form 2)*	107000	67031	45000		14000	
5. Other Funds *(Line5, Form 2)*	1600000	1530510	1600000		1500000	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	18259359	44953215	18230836		18089669	
8. Other Federal Funds *(Line10, Form 2)*	11722622	10621552	13182963		13028977	
9. Total *(Line11, Form 2)*	29981981	55574767	31413799		31118646	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1037000	3023494	2000000		2925000	
b. Infants < 1 year old	4873000	12686230	2500000		2373000	
c. Children 1 to 22 years old	6605000	15515029	6000000		4518454	
d. Children with	4385000	10322078	6300000		5798000	

Special Healthcare Needs						
e. Others	468000	1364755	230836		685000	
f. Administration	891359	2041629	1200000		1810000	
g. SUBTOTAL	18259359	44953215	18230836		18109454	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	838000		1485000		610000	
b. SSDI	100000		94644		100000	
c. CISS	0		0		140000	
d. Abstinence Education	0		814663		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	7575522		8788656		7545078	
j. Education	0		0		0	
k. Other						
ARRA	0		0		876000	
EHDDI	0		0		191899	
Healthy Childcare WA	0		0		350000	
Medicaid Fed & Other	0		0		1800000	
Oral Hlth Dent Ntwk	0		0		500000	
SAMHSA ProjLaunch	0		0		916000	
Child Care Blk ITEIP	0		1100000		0	
T19 XIX Fed	0		900000		0	
Child Care IAR	1200000		0		0	
CP ITEIP	9100		0		0	
Title XIX Fed	2000000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	232000	622057	1600000		655000	
II. Enabling Services	2045000	3643033	4200000		3836000	
III. Population-Based Services	10234000	30323855	5430836		2706000	
IV. Infrastructure Building Services	5748359	10364270	7000000		10912454	
V. Federal-State Title V Block Grant Partnership Total	18259359	44953215	18230836		18109454	

A. Expenditures

Overall expenditures for activities related to pregnant women increased by 94% over FFY08, by 4% for Infants less that 1 year, by 2% for children 1 -22 years, by 3% for CSHCN; 65% for all others and 40% for administration. The increase in spending for Pregnant Women comes primarily from state funding for miscarriage management and oral health. The increases for infants and children 1-22 are due to vaccines. The 65% increase to others is due to Genetics Services activities. A state proviso for Parkinson's Disease Registry meant that the Genetic Services section was addressing issues for older individuals. Administrative spending increased by 40% due to capturing additional overhead in other state funding.

LHJ's receive approximately 60% of the total MCHBG award each year. Beginning in CY2007 OMCH instituted a 2.7% phased- in reduction to Local Health Jurisdictions. To accommodate the cut OMCH developed a funding formula in concert with representatives from the LHJ's and OMCH staff. The formula included a base amount for each LHJ and additional funds for each one determined by such statistics as county Medicaid births.

OMCH funding levels to LHJ's remained at their CY2007 allocations despite continued cuts in activities at the state level. Of interest is a comparison of LHJ spending in FFY08 with FFY09. While timing differences affect the amount of expenditures reported, the office was able to determine changes in spending patterns.

An increase of almost 10% in overall LHJ expenditures supports the earlier assertion regarding the economic squeeze at the local level. Counties are more likely to bill in a timely manner and to use all their allocation.

In FFY08 OMCH projected shifts in LHJ spending by level of the pyramid and this did occur. A 78% decrease in Direct Services indicates that LHJ's were making decisions regarding discontinuing direct service activities and finding other community resources that could fill the gaps. It also indicates that LHJ's are taking advantage of MCHBG's flexibility to use their allocations for activities that are usually not covered by other funding sources. LHJ's increased spending in Enabling Services by about 14%; Population-Based Services by 13% and Infrastructure by 17%. These latter categories speak to efforts to protect core capacity and systems.

B. Budget

Throughout FFY09 the downturned economy and unemployment rate of over 9% meant state agencies had to find more areas for cuts. In early 2009, OMCH developed and implemented tiered rankings to cut lower priority activities by $1.9 million. Unspent state proviso funds in Cord Blood Rule-making and Cord Blood Collection comprised other cuts. Additional reductions occurred from savings due to staff vacancies.

These cuts became permanent for the 2009-2011 biennium. OMCH cut $1.8 million and 3 FTE's to meet the Governor's 1% freeze. Activities related to these cuts included not funding a contract for a school-based health clinic; stopping a media literacy program; not filling vacant positions; not purchasing and disseminating the Epidemiology and Prevention of Vaccine Preventable Diseases book. In the 2009-2011 biennium, other programs such as Cord Blood Pilot, Sex Education Curricula Review, Neurodevelopmental Centers, the Autism Task Force and Miscarriage Management were eliminated or reduced to be phased out. Total permanent funding cuts in General Fund State were $2.8 million with an additional $24.5 million in vaccine funding that was slated for termination May, 2010.

In January 2009, state agencies were called upon to contribute unspent state general funds from early savings. OMCH lost 1.9 FTE's and $140,000.

The legislative session this year brought into existence the Washington Vaccine Association, which will restore Washington to a universal vaccine state at an appropriation of $52 million. OMCH will lose 1 FTE, $77,000 in Oral Health technical assistance work, and $77,000 in contract funds to the LHJ's. Another $438,000 in administrative efficiencies and cuts to program activities will take effect on July 1, 2010. Activities that comprised those amounts were technical assistance

to LHJ's around oral health issues, a staff position and funding for project work concerning web design and maintenance. Some Early Hearing Detection and Diagnosis activities will be curtailed.

In the past two years, OMCH has lost approximately $2 million (app 29%) of state general fund for operations.

State agency staff will also experience temporary layoff days in the coming State Fiscal Year. Current estimates are 10 days. DOH will present the reduction plan to achieve the agency's target amount.
In the face of budget cuts, partners and stakeholders such as the Local Health Jurisdictions have indicated cessation of more locally funded maternal and child health program activities.
Continued unemployment in Washington State means increased pressure for services to the MCH population. The state economist projects that it will be 2012 before the economic upswing will be felt at the state government level.
Changes in funding mean realigning fiscal decisions and office priorities. The Immunizations Program received economic stimulus funding, which will conclude in FFY11. Just prior to the start of FFY11 the CSHCN section has a grant, Epilepsy, which will come to an end. The Oral Health program recently received funding for state dental network activities. A long-standing contract, Healthy Childcare Washington will conclude 12/31/10.
To achieve more administrative efficiencies, OMCH will revise the Activity Plan and Statement of Work for both the Oral Health and MCH programs.
Within these budget parameters, OMCH will deploy block grant resources to maintain core activities utilizing the MCHBG's funding flexibility. To that end FFY11 expenditures will go to 33.3% of activities to benefit Children 1 -22 years of age, 34.5% for CSHCN and 10% for Administration.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.